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## THE

# MEDICAL AND SURGICAL REPORTER.

No. 1370.]

PHILADELPHIA, JUNE 2, 1883.

[Vol. XLVIII.—No. 22.]

## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### THE SEWERAGE SYSTEM OF CAPE MAY.

BY JAMES MECRAY, M. D.,  
Of Cape May, N. J.

In your issue of October 14, 1882, you gave a most excellent editorial on Drainage at Seaside Resorts, in which you say, "Fundamentally good drainage at the sea-shore is very difficult to procure, since one of the most essential requisites is a fall or decline in the land so that gravity may aid the water supply in carrying off refuse, At the majority of our seaside resorts the land is very flat. Also it is very essential that the sewer outlets should be so located that they can freely discharge their contents at all times," etc.

The State Board of Health has been making sanitary inquiry and investigation of all the resorts along the coast, and as they are considered the best authority, I will quote from their report, page 132, 1882, on *Sewers*. A careful examination of the sewer system of Cape May was made. Some changes and alterations which were being made gave an excellent opportunity for careful examination. The city has no map of its underground structures, and like most of our cities, much needs a complete sanitary map. The gradients of the different sewers, could not be obtained, but there was good evidence that they were fairly flushed, and that the fall was sufficient, unless some special hindrance occurs. One sewer, which was being taken up on account of deficiency of fall, illustrated the fact that portions are sometimes laid with too little fall. There is obstruction because there is irregularity of fall

more frequently than because from end to end there is too little fall. In this sewer, the obstruction was found to be caused by a variation in grade which had been made to suit a gas main, and only required the simple remedy of raising the line of pipe before it was reached. The pipes beyond this were so clean as to show a good flushing. The whole system is between three and four miles. As the emptying is into tide water, at points where the tide rises from three to four feet, the outlets are covered a part of the time, but not so long as to interfere with frequent delivery. For this reason there should be more frequent man-holes. (Since last visit of Board of Health, April, 1882, every sewer has been well ventilated.) The sewer pipes are from ten to sixteen inches calibre, and often unnecessarily large. They carry all the storm water which enters by gully-traps. At some of these there is free ventilation. It is much easier to keep sewer-gas out of these sewers, than it is to keep it out of the hotels. We find at Cape May the structural provision for water, for disposal of sewage, and all that relates to outside sanitation, either good or capable of easy correction. There is little danger from sewer-air in Cape May save such as is made in the buildings, and the city has more to fear from them than they have from the city.

Same report says the soil of Cape May is admirably adapted for a city. It is a common fallacy that sandy soils, as being so loose and porous, are the best adapted for close population. The fact, however, is that gravelly soils are much preferable as percolators. The soil which underlies Cape May city is mostly gravelly, with sand under the gravel bed. The water is soft and pleasant—quite

tasteless, unless a slight sulphur taste is perceptible. We think it can be said that the city has a good and abundant water supply. On the whole, it can be said that few sea-side resorts on such narrow strips of land can be found with so good a water supply. The death-rate of Cape May is only 14.12, showing conclusively that the sewers and water supply are good. There are no resorts on the coast that can show so small a mortality.

The question is often asked, "Is there malaria at the sea-shore?" Any one living here knows full well such a thing cannot exist. Salt water will not generate it. Salt mixed with fresh will. Cape May is so situated that fresh water cannot mix with the salt. The Delaware bay and river are salt as far as New Castle, and in droughts as far as the Lazaretto. So there is no fresh water within fifty miles of the Cape. Malaria is unknown among the residents, as will be shown by the return of deaths. Page 341 gives the principal cause.

Typhoid fever, none; remittent fever, none; scarlet fever, one; diphtheria, none; diarrhoea, three; consumption, one; acute lung disease, one; brain and nervous disease, children, five; heart, two; adult brain, one.

#### "PEAR GRIT" AS A CAUSE OF ANAL IRRITATION.

BY DR. J. T. ROTHROCK,  
Of Philadelphia.

For three successive summers my attention has been called to a case for which I can find no exact parallel in our medical literature, and as it presents some marked features, is, perhaps, worthy to place before the medical public; especially as the diagnosis is easy, the treatment merely abstinence from the offending cause, and because, further, it may give a clue to many other cases with like symptoms.

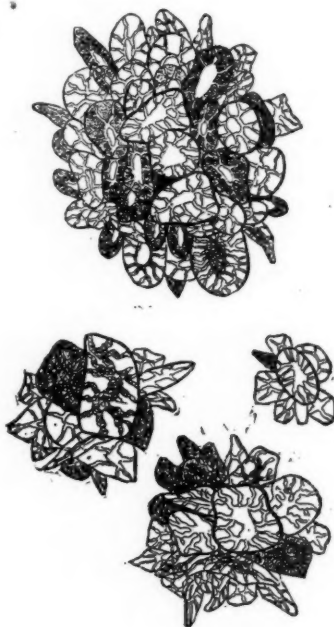
The patient, a middle-aged, strong, active man, very fond of fruit, each summer was taken with what he first supposed a "fit of piles." There was excessive pain on defecation, tenesmus, flattened feces, and a more or less copious discharge of blood. At one time the pain was so severe and so distinctly localized as to lead to the suspicion of fissure or ulcer of the anus.

The periodical return of these attacks was suggestive, and induced an examination for cause.

Among the fruits quite too freely indulged in by the sufferer were pears. This at once suggested the inquiry as to whether the "grit" that all,

even the best pears, contained, might not have to do with the trouble. On mention being made, it at once brought to mind the fact that on the paper used in the closet there were small white hard bodies, never larger than the head of a pin.

Examination by the microscope revealed the fact that in the feces there were quantities of bodies like those shown in the figure—clearly the so-called sclerenchyma, or stone cells, of vegetable histologists. This furnished the clue to the treatment, which was simply to abstain from the pears, a cure always following.



(Barker.)

"PEAR GRITS" *i. e.*, STONE OR SCLERENCHYMA CELLS  
FROM THE PEAR. CLUSTERS MAGNIFIED ABOUT  
200 DIAMETERS.

An idea of the hardness of these cells may be gained from the statement that they are of exactly the same material and hardness as the shell of the hickory nut.

One may readily understand from this, and from the numerous sharp angles a cluster of these cells show, that lodged in the folds of the mucous membrane at the verge of the anus, even if it were not in an inflamed condition, it would speedily become so, and that to an inflamed or ulcerated membrane it would soon prove an intolerable source of distress.

There is this further consideration in connection with other like cases: may they not be caused by similar substances? Does any one, for example, know whether the sharp-faced crystals of calcium oxalate which are found so abundantly in rhubarb, are dissolved in passing through the alimentary canal? We do know that rhubarb is reckoned among the predisposing, if not actually exciting causes of hemorrhoids.

The subject is especially commended to the attention of the profession in the country, where observation in this direction will doubtless show that the case above instanced is by no means a solitary one.

I am indebted to my friend and pupil, Thomas Ridgway Barker, for the illustration which accompanies this article.

#### CONGENITAL ABSENCE OF THE KIDNEY.— TWO CASES.

BY W. A. EDWARDS, M. D.,

Assistant to Prof. Clin. Medical University of Pennsylvania.

During my term as Assistant Pathologist to the Philadelphia Hospital, in the spring of 1882, a foundling was admitted to the house, suffering from marasmus; the babe died in a few days. An autopsy was held, not so much to confirm the diagnosis, as in the routine line of duty. Our work was rewarded by finding the following congenital peculiarity. My notes taken at the *post mortem* table read as follows:

Baby E., foundling, female, age fifteen months, much emaciated, all the thoracic and abdominal viscera normal, but very anæmic. In other words, a verification of the ante-mortem diagnosis.

The kidney of the right side is seen in its normal position, its ureter normal in size; traverses the ordinary course in reaching the bladder. Upon removing the organ its macroscopic appearance is that of a healthy kidney, which *microscopic* examination subsequently proved to be the case.

On the left side the organ and its ureter is nowhere to be found, but in their place the supra-renal capsule is discovered adherent to about the centre of the arch of the diaphragm; it, however, has not the "cocked-hat appearance" ascribed to that gland; it is bound to the diaphragm by firm, well organized connective tissue, which does not appear to have been of inflammatory origin; *microscopic* examination proves it to be the capsule.

No renal artery is given off on this side. Case 2, which is very similar, occurred in private prac-

tice—the child, age twelve months, female, dying because it was a futile effort of nature to vivify the diseased germ, overwhelming constitutional taint attaining the mastery; it was also the left kidney which was absent in this case; the supra-renal capsule was adherent to the diaphragm. *Microscopic* examination made as in the former case, with like result.

In the first case no history was obtainable; the child was found on the hospital steps, so I do not know if it showed any evidence of this congenital defect. The second case was under my observation for some time. The absence of a kidney was never suspected. The urine was apparently normal in amount and color. I never made a critical examination of this secretion, as no symptom seemed to demand it.

These are interesting studies to the embryologist. Why was the kidney in each instance absent and the supra-renal capsule present?

Does it not appear as if the defect was not rare? These two cases were met with within the year. Would the kidney in either case have grown in event of the child surviving, so as to present the "horse-shoe kidney," which we not unfrequently see in adults!

While these cases are not excessively rare, I am tempted to record them on account of the popularity and number of nephrectomies that we see reported in the various journals. If either of these children had reached adult age, and the operation of nephrectomy have been performed on them, it is needless to remark that the consequences would have been disastrous alike to patient and surgeon. That this does occur may be seen by consulting the *New York Medical Journal*, Saturday, February 17, 1883, (a case of extirpation of a displaced kidney by Wm. M. Polk, M. D.)

Perusal of this article suggests the advisability of surgeons determining upon some method by which the presence or absence of the organ can be determined beyond peradventure. Upon scanning the various devices adopted by certain surgeons for this purpose, one is struck with the futility of their endeavors to positively settle the question previous to operating.

#### "OVARIOTOMY."

OPERATION COMMENCED AND DEATH BEFORE COMPLETION.

BY T. H. McCULLOCH, M. D.,

Of Oil City, Pa.

Mrs. D——, farmer's wife, living four miles

from this city, aged forty-three, mother of three children living; one dead; delivered one year ago by craniotomy, at which time she was kept under the influence of chloroform for nearly one hour, with no bad effects as far as anæsthetic was concerned. But from that time her health failed, and she had been under the treatment of quite a number of physicians.

I saw her first on the 27th of last February. Abdomen distended with fluid, which caused great discomfort, interfering with respiration. Not much emaciated. Pulse, 110; temperature, 100°; bowels regular; appetite good, but, as she remarked, "had no room for food." Cheerful, bright and hopeful.

On examining, per vaginam, found a large tumor, rough, nodulated, immovable, filling up the entire excavation. With great difficulty (and some stretching, as it were, of the index finger), I could outline the os uteri in front of tumor, above the pubes, which appeared to be normal. But I could not pass the sound from its misplaced condition. I expressed to her my inability to give an opinion as to the nature of her disease without first tapping and relieving the distended walls of the abdomen.

On my next visit I drew off nearly three gallons of greenish-colored fluid, which revealed a double ovarian tumor; the one occupying the left side of the abdominal cavity, the other pressed down, occupying and filling up the entire excavation.

I explained to her the character of her trouble; that tapping was only palliative; that an operation for the removal of the tumor was either curative or death; and recommended that an ovariotomist be consulted.

Dr. Varian, of Titusville, saw her with me March 29th, and made arrangements to operate on April 2, at which time and in the presence of nearly all our city physicians, she was placed upon the table prepared for the operation.

It was now nearly four weeks since the evacuation of the fluid, and the abdominal walls were distended nearly, if not altogether, as much as before the tapping. The heart's action was good. She was cheerful, and exhibited an unusual amount of stamina for one under such trying circumstances. When spoken to in regard to the chloroform, she remarked, "It was delightful; that when she took it before she never felt better in her life. She thought she was in heaven;" not thinking, I presume, it would be a reality this time.

The anæsthetic used was  $\frac{1}{2}$  chloroform,  $\frac{2}{3}$  ether

(Squibb's), using a small towel surrounded with a cone made with a newspaper. After a few inhalations an exploratory incision was made, some six inches in length, in the median line below the navel, exposing the sac. During this procedure she manifested pain by struggling. More of the anæsthetic was added, and the cone placed over the face. Simultaneous with this, by the manipulations of the operator, the sac was opened. The fluid gushed out, emptying the sac rapidly.

Heart ceased to beat; respiration ceased; face livid; pupils dilated. The tongue was seized with forceps; head lowered immediately; nitrite of amyl applied to the nostrils; hypodermic injections of brandy every few minutes; artificial respiration (Sylvester's method) kept up for forty minutes without any effect. Patient dead.

Post mortem revealed two large multilocular ovarian tumors, with adhesions involving the peritoneum, omentum and mesentery; the womb in a healthy condition, and when dissected out resembled a virgin uterus.

Was death caused in this case by the anæsthetic, or the sudden evacuation of the fluid, or both causes combined?

#### HOSPITAL COLLEGE OF MEDICINE.

Louisville, Kentucky.

CLINIC OF J. A. LARRABEE, M. D.,

Professor of Materia Medica and Therapeutics and Clinical Lecturer on Diseases of Children.

##### Hydrocephalus.

Clinical teaching, gentlemen, is intended to fill a place which no amount of reading, perhaps, can occupy. It is the aim and object of such teaching to present to you from time to time the different phases of disease in as typical a manner as possible, so that you may arrange them in the gallery of memory—pictures, as it were, whose impress will come out distinct in future years. I have been enabled to-day by the kindness of my clinical assistant, Dr. Longest, to present several cases illustrating the more important diseases of the brain, of which we have heretofore had occasion to speak. Most of the children here presented have been treated in this clinic before; some of them at periods quite remote from the present.

This little girl, Minnie Williamson, now five years old, was presented and treated here for chronic hydrocephalus in September last. When she was presented to us she had been the subject recently of rapidly recurring convulsions; there was very marked diminution as compared with the size of the head, of the face and facial muscles, with also considerable emaciation of the extremities. She represents to us a particular class or kind of chronic hydrocephalus. I call your attention to the shape of her head in the first place, although it is now so changed since the time she



was treated as to be scarcely recognizable as the same. The circumference then was twenty-one or twenty-two inches. It still retains the form and shape, however, of the hydrocephalic head. The face as compared with the head is seen to be still diminutive, although if I hide from your view that portion of the face above the eyes, the countenance may be still considered well up to one of her years. This change in appearance you observe occurs then not because the face is smaller, but because the head is larger than it should be. This child represents the hydrocephalic head perhaps better than any picture here. The countenance converges to a point at the chin, and has its greatest divergence at the parietal prominences. Let us then say something concerning these cases in general.

*Chronic Hydrocephalus* is recognized under that name, and distinguished from another form called acute hydrocephalus. This condition is one which we may divide into two kinds or varieties, as regards mechanical symptoms, viz., external and internal. First, as regards the external, we mean as the term implies, that the water is upon the brain—external to it—instead of within it. In the external variety we have the water which produces the deformity, the separation of the bones and the distortion of the features between the membranes of the brain and the brain itself; between the dura mater and the arachnoid, or in the sub-arachnoid space. This effusion is the result probably of inflammatory action, because it is the province of serous membranes when inflamed to produce serous products, and these envelopes when the subject of inflammatory action pour out an amount of fluid differing perhaps in character, but not essentially, from such fluids elsewhere. The point to be observed is this, that the brain substance with its convolutions and divisions is pressed down into the base of the skull by the supernatant water, so that in this case the water occupies the upper portion of the head. In hydrocephalus internus the water is within the brain and the ventricles, which are intended in the normal condition of things, to contain a certain amount of secretion, by the augmentation of which the brain is opened up in the form of the leaves of a book, the brain convolutions being pressed apart, the water occupying the lower part of the cavity of the skull. This classification is important, and the discrimination of these conditions is accomplished not so much from the shape and contour of the head as from the expression of the eyes.

This child to which I now call your attention is a case in which the hydrocephalus is internal. The orbital plates are normally placed in a nearly horizontal position. In the internal variety of hydrocephalus the fluid presses these down, causing them to assume sometimes an almost perpendicular position. This change in the position of the orbital plates results in a like change in the axis of the eye, and consequently in its expression. The expression is downward, the eye bulged from the socket, and the sclerotic exposed. This is a merely mechanical effect of the water. This child has not the power to control the movements of the eyes. A distinction of this character is, however, of no importance in the treatment of the disease.

Here is another case in the person of Wm. Terry, *et. 5 years*. He was treated two years ago at this clinic for chronic hydrocephalus. His head, while then measuring perhaps not quite so much as in the instance of the little girl sitting over there, was nevertheless so large and heavy that he could not support it upon his neck. You see him now so far restored that he is a bright—very bright—and intelligent little fellow. He is able to walk alone, in fact, he goes anywhere he chooses, just as other children of his age, and he has not had a spasm for a year. Here, then, we have two cases of external hydrocephalus, and one of internal, to illustrate the remarks I have to make on this extremely interesting subject—interesting because it concerns in its causes a variety of histories.

The etiology of chronic hydrocephalus concerns the past as well as the present. We may name the causes perhaps on three fingers. As we have often before, we will have here to allude again to the fact that in the study of the diseases of children we are gleaners in the field of practice. We observe the results of these little points which are omitted perhaps in the practice of adults, and as we follow those who practice upon adults, we are perhaps better able to judge of their success in the treatment of the various diseases.

Here again too we may well say we are treading upon the ashes of ruined constitutions, these ashes again disseminated to future generations; for the causes are in the first place tuberculosis, in the second syphilitic diseases, and my own limited experience teaches me to place before either of these intemperance, away back perhaps, on the part of the parents, as having to do largely with the production of this and kindred disorders. These I mention as the principal causes, and some of them begin to operate before the birth of the child, because the accoucheur notes that it is not unfrequently the case that he has to resort to various means to accomplish the birth of children whose heads are enlarged, and who are the subjects of this disease in utero. The causes of the disease then having spent their activity, and the effect remaining, these cases are generally unpromising. If we succeed in enabling them to bridge the difficulties incident to infancy, they usually succumb to those of childhood which come along afterwards, as the eruptive and epidemic diseases. Weakly by birth, and sickly by inheritance, when they meet the pitfalls that beset the path of childhood, they readily succumb, seldom reaching the period of adult life. It is perhaps fortunate, because, unable to care for themselves, they become an incubus upon their families and perhaps upon others.

Tubercle, in my estimation, should rank very high as an element in its production; whether or not there are present inflammatory processes of a low grade, we are not able to say definitely. I incline to the belief that, at least in the internal variety, such an inflammation of the lining membrane of the ventricles is present, a condition similar in many respects to basilar meningitis.

We have foreshadowed the times at which these diseases may occur. They generally show the first symptoms by a change in the expression, and by the early occurrence of convulsions. Convulsions do not originate the disease, however,

and it must make considerable progress before convulsions occur. These convulsions mark the progress of the disease, the pressure then taking place, and the absence of convulsions mark that period which is characterized by its quiescence. Mark, for instance, the periods of repose in tubercular deposit of the mesenteric glands. With the development of the convulsions you have the gradual emaciation, the wasting and atrophy of tissue, a want of assimilation; the limbs are small, dentition is delayed, and the head makes its impress upon the pillow with a wet spot—a mark always of debility. About this time another symptom of importance appears: the child frequently puts its hands to its head for hours at a time, and sometimes presses its fingers into its eyes; certainly a singular performance for a little child. All the symptoms which go to make up a disease in childhood differ from those attendant upon the same disease in adult life. Pain as felt by the adult is one thing; in the child, very different in its manifestations. As a general thing, you may make this distinction—the child, when the subject of continued pain is the subject of organic disease; this may or may not be true in adult life. So that if a child manifests the evidences of pain for days together by pounding the head with the hand, bowing down upon the floor, bumping the head against a door, etc., you may be certain a structural disease is present.

In hydrocephalus, the muscles of the neck become extremely weak and emaciated. This is a fact of importance when you come to make the distinction between meningeal inflammation, giving rise to pain in the head, and hydrocephalic symptoms. When meningitis gives rise to pain in the head, the head is fixed. In hydrocephalus the head rolls in any direction. I take it, however, that the principal point which would make your distinction in the diagnosis is the gradually increasing distension of the fontanelles, which, as you know, should be completely closed at the second year.

The case I show you now is illustrative of the syphilitic variety of the disease. I have already investigated the case far enough to learn that the history is one of that diathesis. The child is perfectly blind from syphilitic keratitis; it has been the subject of eruption since birth, and these effects of the operating cause have preceded the development of the hydrocephalus proper.

In the treatment of these cases, we have endeavored to represent, as far as possible, the different causes.

In the first case presented here there are unmistakable evidences of the strumous diathesis; the child has had extensive abscess in the hip joint, which was evacuated at the time by the aspirator, resulting in a cure without leaving any deformity worth mentioning, except shortening of the limb. In the treatment of such cases, as in the treatment of all others of malnutrition, recourse must be had to reconstructive agents. It has been proposed by some to tap the head and evacuate the fluid, afterwards resorting to strapping to prevent its refilling. I question the propriety of such a proceeding; not through the fear of immediate death, but from the improbability of such treatment relieving or preventing a second effusion.

Those who have watched closely the clinical history of the effusions of pleurisy will, I think, bear me out in the remark that they are seldom thus cured.

In this second case, the treatment was by mercurial inunction. This treatment was followed out for some time, and under it the child began to improve; not at first with regard to the observable symptoms, but with regard to the nutrition; and by continuing the treatment all this improvement has been brought about. The first case was treated by reconstructives entirely, the iodides and malt. I believe we have in malt properly made one of the best reconstructives known. This child has taken a great deal of it. It does good in all those cases in which malnutrition stands in the relation of cause to effect. This blind skeleton of a child has undergone no treatment whatever, though it has been under my continued observation for some time. It has been the subject of large sloughing sores. At that time it was treated with some mercurial inunction, but it was thought the child would soon die, so nothing further was done. At one time it had such an odor about it as to be almost unbearable, necessitating the use of chlorine and Labarraque's solution.

Let us now consider some of the other diseases of the brain closely related to this. In the first place I wish to fix upon your minds the significance of certain terms used, and confused in the minds of students. Of course we may have inflammation of any part. Different membranes surround the brain and spinal cord, and differentiation has been made in regard to diseases of the brain on the basis of the technicalities used to designate the parts, as you might coin for instance such a term as "piaitis." Such distinctions, however, if they might be discriminated during the life of the patient, I am not prepared to say would be of any particular benefit in the treatment of the disease; yet it is important that the diseases affecting these membranes should be differentiated from those producing hydrocephalus. Between acute and chronic hydrocephalus there is this distinction: An active inflammation of the brain coverings was formerly designated acute hydrocephalus; the term is now abandoned, and this inflammation designated as simple meningitis. The result of an inflammation of these membranes of any character is an effusion of serum upon or between the membranes of the brain. There is a form of acute inflammation also which we call tubercular meningitis, and of these forms of acute inflammation the tubercular is present in more cases than the simple, and meningitis in some variety is extremely common in children. Dr. West in his admirable work on Diseases of Children, I think says 9 and a fraction % of all diseases from which they suffer consist of some form of meningitis.

In simple meningitis a different set of causes operate to produce the disease. Suppressed eruptions, whether they be of the so-called eruptive diseases or manifestations upon the skin of various kinds, and perhaps more frequently than all the injudicious treatment and suppression of discharges from the ear by pledgets of cotton introduced, whereby structural disease of the bones takes place. More cases in practice come under

the observation of the physician of meningitis caused by the suppression of discharges from the ear, or perhaps from treatment of diseases of the ear or by delayed treatment of such diseases, than from all other combined causes. It may be a result of that process we so familiarly know as "taking cold;" it may be the result of the circulation of disease-poisons in the blood. This form occurs in the inception of such diseases as small-pox, scarlet fever, and rheumatism. It may be the result of various constitutional peculiarities, as where there is a tendency to diseases of the nervous system, as for instance from the complications from typhoid fever, etc. Again, it may be the result of so simple a disease as that we call whooping cough, a disease never fatal of itself, but sometimes so because of the complications which it causes.

I saw a case this morning which looked like a commencing case of pneumonia. The child had had the whooping cough for four or five weeks; it now suffered from a sudden rise of temperature, suppression of the cough, spasmodic blushes over the skin, and labored and restrained respiration. I was about to pronounce it incipient pneumonia, but more patient examination led me to believe it was suffering from congestion of the brain, the effect of whooping cough, and I so treated it, and will in all probability so relieve it. A mistake in the diagnosis, under such circumstances, followed by the course of medication such diagnosis would indicate, is almost necessarily fatal.

The symptoms which usher in an attack of simple meningitis are usually plainly marked, and essentially different from those which precede the development of chronic hydrocephalus. I have lately been able to prevent the development in a child of meningeal inflammation by an early recognition of the initial symptoms by appropriate treatment. The symptoms attendant upon the initiatory stage are usually a change in the child's disposition. Moroseness and fretfulness, perhaps, attracts the attention of parents, but seldom excites alarm. In the case to which I allude, the child, from an amiable, happy, cheerful creature, was changed into a morose, fretful and peevish child, almost constantly filled with fear. I found she had not slept for several nights; that there was intolerance of light and contraction of the pupils; there had been vomiting. There had been no crying with all her madness. The cry in simple meningitis is not attended by the increased secretion of tears which usually occurs in grief. As long as tears flow freely during a cry, there need be little apprehension of serious brain trouble. With these symptoms we have a particular kind of vomiting—vomiting not preceded nor attended by nausea, vomiting by central irritation. After this, the appetite is good, and the child sometimes eats voraciously. This symptom, combined with constipation, puts you on your guard. Cases often arise in which it is difficult to distinguish the disease from remittent fever. While it all seems plain to talk about, yet when you come to the bedside of the individual you will oftentimes find yourself puzzled. You may find the child presenting all the symptoms here mentioned, save that in stead of constipation the child has diarrhoea; that one thing throws you off adrift. I would teach you, therefore, to depend upon the

grouping of symptoms, letting pathognomonic symptoms pass.

A word, now, upon the tubercular variety. In this form there are found after death depositions of tuberculous matter scattered like millet seed along the course of the vessels. Here, as in tuberculation of the lung, a prodromal stage, which may or may not have been noticed by the friends, exists. This form is more common than the other variety, and infinitely more fatal. Indeed, I would certainly be very skeptical as to the correctness of the diagnosis when recovery is said to occur from this form. Among the initial symptoms will occur weariness, lassitude, hectic fever, giddiness, vomiting, and constipation of the bowels—there may be diarrhoea, as sometimes occurs in infiltration of the mesenteric glands. A case of this kind closely resembles typhoid fever. I have seen cases of this description treated for four or five days under that diagnosis. I call to mind a case that occurred under my notice a few weeks ago. At that time the mother was not even alarmed. I predicted then the result which has since been fulfilled by the death of the child.

Tubercular meningitis is followed by paralysis of motion of one arm or leg; when this stage in the case is reached, I advise you to say that the child will inevitably be lost, and never change this prognosis because of any sudden change in the appearance. I could not tell how often I have been called to the bedside of these little patients to hear the statement that the child is better, and to be besought to continue my efforts to save it. Do not allow yourselves to be deceived by such ignes fatui as these. It is the mere flicker of the candle before it goes completely out. Nothing is more common in brain troubles of this description than to have this lighting up of the symptoms.

Here, now, is a boy who has been the subject of circumscribed simple inflammation at the base of the brain. His condition was diagnosed at the first visit to be such, and the parents then informed that it might concern in its effects some of the nerves which find their origin here. One of the products of simple inflammation is lymph, or semi-organized material evenly spread over the surface of the membranes. In the tubercular variety, post-mortem reveals only the tubercles studded along the courses of the vessels, and fluid; but in this case we are concerned in the character of the product deposited. Here, after an unpromising period of weeks, the boy emerged from a comatose condition to display the symptoms of a chronic form of inflammation. Long before this state, however, hearing was completely lost. This is the result of the involvement in the process of the auditory nerve at its origin. Otherwise, this boy's intellect and perception is good. It is possible that under the administration of such agents as iodide of potassium, he may recover this lost sense. I have had such a case to recover spontaneously in the person of a child at Danville, even after the lapse of a sufficient period to permit of a considerable degree of education in a deaf and dumb institution.

I have now another case illustrative of an entirely different class of brain affections. This case I show also on account of its novelty. It is scarcely probable unless you practice in mountainous districts that you will see another like it.

This is a case of cretinism. By cretinism is distinguished a class of individuals who, although in the animal scale they are perfectly developed with the exception of the power of locomotion and in height, have brains that are dwarfed and stunted to such an extent as to render them hopeless and helpless imbeciles. The condition here presented, however, is very different from idiocy. We have with us various grades of brain development, and those who practice among children will soon remark the different grades of development and intelligence displayed in childhood. Idiots are quite common; cretins are not common in this country. Our knowledge of the cause of this condition is very limited; however, it has come to be associated with certain climates: aside from this, various causes are able to impress the growing brain to arrest or prevent entirely its development; it may receive an impress which forever stamps it with imbecility. The disease, as I have said before, occurs in mountainous districts. Altitude rather than latitude has to do with its production, and a singular fact about it is that it always occurs in connection with another disease of altitude, viz., goitre. Goitre is essential to cretinism. The mother of this child I here show you has the goitre well developed. The child you observe has a well-shaped head and a good countenance; there is no idiotic stare there. Another peculiarity about these children, noticed in the countries where they most frequently appear is that they are wonderfully free from the diseases incident to childhood—measles, scarlet fever, whooping cough, etc., etc., they escape them all; why we do not know, but there is this it appears to me hinted in the fact, viz., the necessity of the integrity of the nervous system as a factor in the production of disease. The ignorant Alpine has a consolation, however, which this mother under more intelligent surroundings can hardly feel. Among them they are called God-children. They believe these children are perfectly formed in every respect of body, but that when they descend to the earth, through the power of the Almighty, their souls are kept in heaven, and that when they die their bodies go to make the perfect being by union with their souls in heaven.

As to the exact pathology of the disease we know nothing. We have then simply to show you the case and leave it as we find it, a case of cretinism.

## MEDICAL SOCIETIES.

### OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated meeting, Thursday, April 5, 1883.

The President, R. A. Cleemann, M. D., in the chair.

Dr. W. Goodell exhibited some

#### Calcareous Particles Passed per Vaginam.

The previous history had been that of menorrhagia, and multiple fibroids were found in the womb. One of these fibroids had evidently taken on calcareous degeneration, and had subsequently broken down and discharged these fragments into the uterine cavity. He stated that these parti-

cles were not true bone, but merely the product of a disorderly deposit of lime, which possessed none of the osseous elements, not even cartilage corpuscles. This calcareous degeneration tends to cure the disease by breaking off the vascular filaments of attachment and lessening the nutrition of the fibroid. In one instance, the specimen of which is now in the Museum of the University of Pennsylvania, he had seen three fibroids wholly converted into stone. These stones were, however, very light, and not like those of the bladder. It was the expulsion, *per vaginam*, of these uterine calculi, which had greatly puzzled the older anatomists.

Dr. Goodell also exhibited two calculi, and related the following histories of two cases of

#### Stone in the Female Bladder Associated with Fistulous Connection with the Bowels.

The first case was that of a patient of Dr. C. A. McCall, who sent her to him in October, 1881. For the preceding four years she had suffered very much from vesical tenesmus. She frequently broke wind *per urethram*, and often passed through the same channel the seeds of raspberries, of tomatoes, and of pears. A year before Dr. Goodell saw her she had voided a great deal of her urine *per rectum* for several weeks. Dr. Goodell detected two stones in the bladder, and removed them. At once all the fistulous connection between the bladder and the bowels disappeared, and the patient got well. This rapid recovery led him to think that there had not existed any fecal fistulae, but that the vesical tenesmus was so great as to cause a rectal tenesmus, which was masked by the former, and that the seeds and wind were voided *per rectum* unconsciously by the woman when attempting to empty the bladder. But he had been led to change his views by the following case, which he had seen with Dr. Wm. Corson, and which Dr. Ellwood Corson was kind enough to report for him.

Misled by the first case, Dr. Goodell was not at first disposed to admit the existence of a fecal fistula, but from the subsequent history of the case there can be no doubt of it. In this case he believed that a pelvic abscess had burst into the bladder, and also into the rectum or small intestines, which had established the communication between the two viscera. Like the first case, as soon as the calculus was removed the fistulous tract closed, and the patient got well.

Mrs. R—, American, aged fifty years, the mother of five children. For three or four years prior to November, 1881, she was troubled occasionally by the passage of small calculi; but her health was reasonably good, with the exception of backache and an almost constant pain in the right iliac region. She often expressed her belief that there was something growing in the right side. There was no tumefaction in that region, and her opinion was based on the pain and distress she felt. She never applied to her physician for relief of this suffering. She was also troubled with constipation.

In November, 1881, she made a visit to the country and took a long walk. On her return home she had a constant desire to urinate, and she then noticed, for the first time, that her urine had an unnatural color and a very unpleasant



odor. The quantity passed was not excessive. This condition continued for five or six days, when there occurred a sudden gush from the bladder of a very offensive mixture of pus and urine, accompanied by great pain and straining. Her pain and distress became so great and was so augmented by being on her feet, that she was compelled to remain in bed. After the free discharge occurred, the pain in the right iliac region ceased, and she has never had any return of it. As she was troubled with constipation she was directed to eat stewed prunes, and she soon noticed that the prune skins came from the bladder, as did other articles of food, along with the urine. Every day she was troubled with the escape of gas through the urethra, and this gave her as much pain as the passage of solid matter. She says that she occasionally passed urine through the rectum. She became greatly emaciated, and was but partially relieved of her suffering by the constant use of morphia.

Until January 20, 1882, she was under the care of homœopathic physicians. On that date Dr. Wm. Corson was called to the case.

February 10th, Dr. Wm. Goodell saw her and diagnosed stone in the bladder.

February 20th, she was etherized and the urethra dilated, and a digital examination proved the existence of a calculus, about  $\frac{3}{4}$  of an inch in diameter, attached to the fundus of the bladder. This was removed by Dr. Ellwood Corson. In attempting to dislodge the calculus, it crumbled on slight pressure with the extracting forceps, and proved to be a mass of fecal matter with a calcareous crust, but slightly thicker than an egg-shell. While she was under the influence of the anæsthetic, an attempt was made to wash out the bladder, but after injecting  $\mathfrak{f}\overline{\text{ss}}$  xij of water, and finding that it escaped into the interior of the body and did not remain in the bladder, the washing-out process was discontinued. After she regained partial consciousness and made a strong straining effort, the injection came away through the urethra. As there were some doubts expressed as to the possibility of there being an opening from the bowels to the bladder, she was induced to eat a few stewed figs and the seeds were seen to come from the urethra; on another occasion  $\mathfrak{f}\overline{\text{ss}}$  viij of carmine-colored water was injected into the rectum and was immediately drawn from the bladder by means of a catheter. After the removal of the calculus it was thought proper to keep the bladder washed out daily with warm injections, and to regulate the bowels with mild aperients; but after persisting in this course of treatment for four days it was abandoned, as it caused her great discomfort and did not improve her condition. Afterward she was allowed to eat such food as the system craved, care being taken to select such articles as would not leave an irritating residuum. She rapidly improved, and since April, 1882, has had no trouble with her bladder. If she eats acid fruits or drinks lemonade she has some irritation in passing urine. That there was a fistulous opening from the bladder to the rectum, there can be no doubt; and when we take into consideration the fact of an abscess forming somewhere in the right iliac region and opening into the bladder, and that the food passed from the bladder in a semi-digested state, and the absence

of a fecal odor, there is a strong probability that there was also an opening from the small intestines into the bladder.

Dr. J. C. Morris has seen two cases of pelvic abscess bursting into the bladder. One case was in the person of a night nurse at the Episcopal Hospital. A tumor in the lower part of the abdomen first attracted attention. The uterus was drawn up out of reach of the finger when making a vaginal examination; an inflammatory mass could be felt between the uterus and bladder; every half hour a mixture of urine and pus was voided *per urethram*. If a catheter was passed into the bladder and turned to the right, urine escaped through it; but if it was passed to the left, nearly pure pus passed through it. Examination with the sound showed a large fibroid in the anterior wall of the uterus. This tumor having undergone purulent degeneration, and a fistulous opening being established into the bladder, the pus escaped through the bladder. A galvanic stem pessary five and a half inches long was introduced into the uterus, and was finally successful in effecting its reduction to the normal size. This woman died of fibroid phthisis, and at the *post-mortem* examination the uterus was found but slightly enlarged and the fistula into the bladder was not seen, but a communication from the small intestine into the bladder was discovered.

Dr. Wm. H. Parish had seen one case of fistulous communication between the bladder, vagina and small intestines, resulting from an attempted abortion, and consequent cellulitis. After long-continued pelvic symptoms, food commenced to pass through the bladder and the anterior and upper portion of the vagina. Water injected into the vagina passed into the bladder, but a sound could not be made to follow it. The food which passed through the fistulæ was incompletely digested.

Dr. Elliott Richardson read a

#### Report on Results of Post-mortem Examination of the Body of Lina Earl.

This woman was operated upon September 22, 1880, for removal of a living child from the uterus by Cæsarian section, as modified by Porro and Müller. A report of the case was published, *Amer. Jour. of Med. Science*, January, 1881. The immediate results of the operation were in every way favorable. The child was living, and the mother made a speedy recovery.

She died in New York city on February 24, 1883, two years and five months after the operation. She had been for two years previous to her death at times an invalid, and was under my care occasionally for the treatment of attacks of acute rheumatism, anemia, etc., to which her life of hardships and exposure as an exhibiting curiosity rendered her peculiarly liable. The more recent symptoms which appeared during the last illness I did not witness, but learned were attributable to defective action of the kidneys.

At the post-mortem examination, made about 9 p. m. on February 24th, ten hours after death, there were present Drs. Satterthwaite and Hegeman of New York, and myself.

Inspection of the body showed the long bones of the extremities to be deformed as in rachitis; deformities which had not been so apparent during life. General anasarca was present. On the

surface of the abdomen a cicatrix was observed extending from a point about  $1\frac{1}{2}$  inches above the umbilicus to within about  $\frac{3}{4}$  inch of the symphysis pubis. This cicatrix was the remains of the abdominal incision made at the time of the operation for her delivery, and occupied the linea alba directly in the median line, except that at the umbilicus it was deflected to the left. Nearly the whole of that portion of the cicatrix extending between the symphysis pubis and the umbilicus was the site of a large hernia, which, however, did not extend into the latter. This hernia I had seen during the patient's life. It began to appear about six months after the operation, and received no treatment whatever until by its size it became inconvenient; then a bandage or truss was applied, and this she wore constantly until her death. The production and enlargement of the hernia had been greatly favored by the woman's course of life as an exhibitor of herself and child, for the latter she lifted up and held in her arms many times a day, in order to display it to her visitors, even after it had become much too heavy for her to carry.

The body was opened by a long incision from the top of the sternum to the symphysis pubis. This incision was deflected to one side opposite the cicatrix of the old abdominal wound, in order that the relations of this to the abdominal contents might be more closely observed. The body, as before stated, was anasarcaous throughout; some clear serous fluid was found in the peritoneal cavity, and a good deal in the cavities of the pleural and pericardial sac. I very much regret that I have no data of microscopic appearance of any internal organ or tissue to give. Only the gross lesions which could be detected by the unaided eye in a hasty examination can be given. The heart was not opened, but the left ventricle appeared abnormally large. The lungs were oedematous, and pneumonia of the right side was observed. The spleen was enlarged. The liver presented an appearance of fibrous or "hob-nail" degeneration. The kidneys showed unmistakably the existence of Bright's disease. The abdominal and pelvic cavities gave no evidence of any peritoneal or cellular disease. The hernia was found to be covered by peritoneum and skin; the remaining structures having parted to admit the protrusion of the intestines and peritoneal covering. No adhesions between the cicatrix and subjacent structures could be detected, except at the lower angle of the wound. It was at this point that the stump of the uterus had been fixed in a manner similar to the disposal of the pedicle in ovariectomy. A fibrous band was found extending from a depression in the abdominal wall at this point, to a body consisting of the remains of the uterus.

Dr. Satterthwaite, who examined these specimens, writes me that this body, which occupied nearly the normal position of the cervix uteri, except that it was displaced somewhat anteriorly, presented the following characteristics: "The extreme length of the stump was 4.75 cms. (1.87 inches); vertical thickness, 2.5 cms. (1 inch); its breadth, 1.5 cms. ( $\frac{3}{4}$  inch). On attempting to pass a uterine probe into the os externum, it was found to enter with difficulty, though the cervical canal was capable of admitting a No. 10 (English)

sound. The mucous membrane was coated with a deposit of white, thick, gelatinous material, and was intact for a distance of 3.5 cms. ( $1\frac{1}{4}$  inches). No naked-eye evidences of cicatricial tissue were made out at the amputated extremity of the neck."

Examination of the pelvis *in situ* was of much interest to me. Measurement of the superior strait gave for the

Conjugate diameter, 2 inches exactly.

Transverse diameter,  $4\frac{1}{4}$  inches.

Oblique diameter,  $4\frac{3}{8}$  inches.

The pelvis was a rachitic one, although the pavilion did not present the wide-spreading ala or the diverging anterior-superior spinous processes of the ilia, which are the usual deformities of rachitis in this part of the pelvis. The true pelvis, however, presented highly characteristic deformities. The sacrum was at its upper part dislocated, and pressed downward and forward into the pelvic cavity, while the lower extremity being held by ligamentous bands to the ischiae and pubic bones, caused a sharp bending forward of the last three vertebrae of the sacrum. This deformity implied abnormal softness and pliability of the bone at a time when the individual was of sufficient age to either stand or sit erect, so that it alone is conclusive evidence of rachitis having existed. The normal curvature of the pubic bones was nearly lost, so that they receded from the symphysis in nearly straight lines backward and outward to join the ischiae and ilia, the two pubic bones, when viewed from above, forming an abnormal angle at the symphysis. The shape of the superior strait was therefore obtusely cordate, deeply indented at its base by the promontory of the sacrum projecting far into it. I was much surprised at the evidences of rachitis, which became more and more conclusive as the examination proceeded, since the history of the patient formerly given me was that of excellent health from birth to the time of the operation in 1880, and we were told by the woman and those who had known her best in early life, that she was in figure almost an exact counterpart of her father. These facts, as I supposed them to be, led me to believe that her shape was due to arrested growth, and not to rachitis. It will be interesting to know that the child of this woman is now living, that he is well developed, and presents no deformity nor any symptom of rachitis. He is of fair size for his age.

In closing, I would draw the following conclusions from the examination:

1. That the deformity of pelvis and extremities was due to rachitis.
2. That the operation had nothing to do with the patient's death.
3. That the operation caused the patient no inconvenience except from the hernia which would either not have become developed, or at most would have been small, had it not been for the exposure of the woman to unusual strain, and her total neglect to resort to any treatment until the hernia became large.
4. That success in so far as the woman was concerned would have been possible, and even probable, with diameters so large, if embryotomy had been resorted to in this case; but the operation would still have been dangerous, and the child would necessarily have perished.

Dr. R. P. Harris remarked that of five Porro operations in this country, four have proved fatal.

This is the first successful operation in which a *post mortem* examination has been obtained after entire recovery.

In reply to Dr. A. H. Smith, Dr. Richardson stated that no trace of a fistulous opening between the stump of the uterus and the abdominal wall existed at the time of death.

Dr. B. F. Baer read the history of a case of **Suppurating Cyst of the Broad Ligament, which had Perforated the Bladder,**

and exhibited the specimens removed by laparotomy. (The case will be published entire in the *Amer. Journal of Obstetrics*.) The characteristic points were chills, exhaustion, anorexia, tenderness throughout the lower abdomen, and a small painful tumor in the left iliac region, with great irritability of the bladder. Pulse 120, temperature 100° to 102°. The tumor extended down between the bladder and the uterus, and the latter was retroverted. Douglass' cul-de-sac was occupied by a thin-walled fluctuating cyst about the size of a large orange. The uterus could be moved slightly from side to side. The anterior tumor rested on the bladder and was adherent to it. The history showed a slowly growing cyst with purulent contents, commencing about three years before, when the first chills and a mild septicæmic fever had occurred. Gradual emaciation had been progressive since that time. Tympanitic resonance of the tumor gave evidence of decomposition, with evolution of gas. When the catheter was passed before operating, several ounces

of very fetid pus flowed through it, showing a spontaneous rupture of the cyst into the bladder. The cyst was found adherent to the abdominal wall and to the bladder, but not to the intestines nor uterus. The cyst was aspirated and removed by laparotomy. The pedicle, consisting of broad ligament and fallopian tube, to which the left ovary was adherent, was transfixed and ligated. The cyst in Douglass' pouch arose from the opposite broad ligament; it had formed no adhesions, and was removed without evacuation of its contents. The ovary and fallopian tube were healthy, and were not removed. The aperture in the bladder through which the contents of the cyst had escaped was valvular, and was closed by the compression furnished by the external dressings. The patient died from exhaustion soon after the close of the operation.

Dr. Baer introduced cases from W. L. Atlee, Peaslee, Keith, Geo. F. French, and Goodell, to prove the correctness of the principles upon which he operated.

Dr. W. H. Parish thought Dr. Baer's rules safe and sound; he had removed a suppurating cyst with anterior adhesions. An experienced operator who was present recommended delay; but feeling sure of the correctness of his own principles, he removed the cyst and the patient recovered. In another case in which a fistulous opening discharging pus existed, suppurative peritonitis was diagnosed, but after death from septicæmia, a *post mortem* examination revealed a suppurating cyst of the ovary.

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### Are Phthisis, Bronchitis, and Pneumonia Epidemic Diseases?

Before the Epidemiological Society of London (*Lancet*, April 14, 1883), Dr. G. B. Longstaff read a paper on Phthisis, Bronchitis, and Pneumonia: Are they Epidemic Diseases? The following is an abstract:

The author explained that his object was to examine the Registrar-General's returns in such a way as would make clear their bearing on the solution of the question propounded. As in previous papers, relating to summer diarrhoea and the diseases allied to erysipelas, respectively, he exhibited diagrams graphically representing the death-rates for England and Wales from the diseases in question, and certain others in various ways allied to them, during a period of twenty-five years; also showing the same death-rates in London for thirty-three years, compared with a curve expressing the number of cold days in each winter. Many other curves had been pointed out by the author, but only a few had proved useful for the purpose in hand. One diagram showed

that the death-rate curve of phthisis deviates but very little from a straight line, resembling in this respect those for cancer, apoplexy, paralysis, convulsions, and fractures. The curves of tubercular meningitis (hydrocephalus), and to a less degree tabes mesenterica, resembled the phthisis curve. The phthisis death-rate had fallen 20 per cent. during the last twenty years. The bronchitis curve exhibited considerable fluctuations, but on the average it had risen 81 per cent. during twenty years. Pneumonia gave a curve closely resembling that of bronchitis in many respects, but the average mortality had fallen 20 per cent. The total mortality from all diseases of the respiratory organs, together with phthisis, showed an increase of 5 per cent., indicating that probably many deaths formerly returned as due to phthisis or pneumonia were now classed with bronchitis. Pleurisy appeared to be more allied to rheumatism than to respiratory diseases. From the curves relating to London deaths, it appeared that bronchitis and pneumonia corresponded with the coldness of the winters, but not so closely as might have been expected. Phthisis was but little affected. Curves derived from Messrs. Buchan and Mitchell's paper on the Infl-

ence of Weather on Mortality, showing the average weekly fluctuations of the death-rates from various causes in London during thirty years, strongly confirmed the author's conclusions, with the single exception of *tabes mesenterica*, which gives an entirely different curve from that of phthisis. In another diagram were exhibited the week-to-week fluctuations of the deaths from bronchitis and pneumonia during the last five winters in London, and their relation to cold; also the same for phthisis during two of the winters. This diagram showed clearly that the pneumonia death curve had a general correspondence with the bronchitis death curve; but it differed in two particulars—viz., the fluctuations were much less, and while it rose in the autumn as rapidly, it fell in the spring more gradually. In the spring of 1879 there was a prolonged high mortality from both bronchitis and pneumonia out of proportion to the severity of the cold; and during the whole winter 1878-9 the two curves of bronchitis and pneumonia corresponded less closely than in the others. The effect of two hard winters upon the phthisis mortality was shown to be remarkably slight. It was noted that for every 1000 females who died of pneumonia not less than 1460 males died, whereas in the case of bronchitis the numbers were 1000 females to 1104 males, and in the case of phthisis 1000 females to 1046 males. Bronchitis caused nearly three times as many deaths in proportion to population in Lancashire as in Gloucester. The mortality was also very high in metropolitan Surrey and Middlesex, West Yorkshire, Warwick, and Monmouth. It was very low in Cornwall, Sussex, Norfolk, extra-metropolitan Surrey, Cambridge, and Gloucester. Pneumonia was most fatal in Lancashire, Monmouth, South Wales, West Yorkshire, Stafford, and metropolitan Middlesex and Surrey; least in Sussex, Wilts, Hants, Bucks, Oxford, North Yorkshire, and Westmorland. In eight registration counties pneumonia was found to be comparatively much more fatal than bronchitis—viz., South Wales, Gloucester, Rutland, extra-metropolitan Surrey, Bedford, Cornwall, Monmouth, and Cambridge. In ten registration counties bronchitis was found to be relatively more fatal than pneumonia, viz., North Yorkshire, Warwick, Wilts, metropolitan Surrey, Cumberland, Nottingham, Westmoreland, Cheshire, Somerset, and Oxford. The author's main conclusions were: 1. That the mortality statistics of England and Wales did not give any evidence in favor of the view that phthisis is communicable, but they showed, on the other hand, that weather had very little influence on the phthisis death-rate. 2. That while bronchitis and pneumonia were both greatly influenced by meteorological conditions, it was difficult to explain by those conditions alone all the phenomena. 3. That common catarrh was a communicable disease, and that it was probable that very many cases of bronchitis and pneumonia might be looked upon as complications of that or some similar disease of mild character when uncomplicated. 4. That the different incidence of bronchitis and pneumonia on the two sexes pointed to some difference in the causation of the two diseases. 5. That there would appear to be some common factor in the causation of phthisis and tubercular meningitis.

#### Excision of the Entire Tongue by Scissors.

Dr. Frederick Treves reports four cases in the *Lancet*, April 21, 1883, in which the entire tongue was removed by what is known as Billroth's method. The procedure adopted in each of these cases was precisely the same, and was briefly as follows: The patient having been anesthetized, the linguals were first secured in the neck. Each vessel was reached by a curved incision that commenced behind a point some little way below the jaw, opposite the anterior edge of the masseter, and that was continued down to the level of the hyoid bone, and finally carried up to a point behind and below the symphysis menti. The sub-maxillary gland having been displaced, the artery was exposed by cutting through the hyoglossus muscle in the floor of a triangle formed above by the ninth nerve, and below by the converging bellies of the digastric muscle. In no instance was there any difficulty in securing the vessel, although, owing to the depth of the incision, the proceeding is somewhat tedious. Care should be taken not to disturb the sub-maxillary gland more than possible, and it is most desirable that no part of the gland should be included in a ligature.

Both arteries having been secured, the mouth is forced open by a Mason's gag, and the tongue drawn forwards by means of a stout ligature passed through its anterior part. The entire organ is then cut out with a pair of strong, straight scissors. The frænum is first freely divided, and one blade of the scissors being thrust beneath the mucous membrane of the floor of the mouth, that structure is divided on each side between tongue and the jaw, as far back as the epiglottis. Returning again to the middle line, the hyoid muscles are divided from before backwards, and, after a few vigorous snips with the scissors, the organ is free. The bleeding that follows is very insignificant, and usually is immediately arrested by firm pressure with a sponge.

For the first three days after the operation the patient is fed entirely through an India-rubber catheter passed into the gullet from the nose. On the fourth day he is able to feed himself, and usually finds it most convenient in swallowing his food to place the head very much to one side, so that the fluid may run by the side of the larynx into the œsophagus. The patient is up on the seventh day, if all goes well, and strong enough to leave the hospital by the tenth or eleventh day after the operation.

He thinks that the following advantages may be claimed for this procedure of Billroth's:

1. It is comparatively simple, and requires no elaborate apparatus.

2. By its means more of the tongue can probably be excised than can be removed by the écraseur, no matter how applied. With the écraseur it is somewhat difficult to vary the exact amount to be removed in particular cases, since the surgeon can only deal with what can be included in a noose. It may be noted, moreover, that with the scissors an extensive excision can be performed without such complication as division of the jaw or cheek, or an opening into the floor of the mouth above the hyoid bone.

3. The procedure is practically bloodless, and the great source of danger in tongue operations is thus removed. It appears to me that on this



ground Billroth's method is infinitely superior to Mr. Whitehead's modification of the same. Mr. Whitehead, it is well known, removes the tongue with scissors, but without previous ligature of the lingual arteries. The operation has been successful in the skilful hands of the surgeon who introduced it; but it would seem to subject the patient to a totally unnecessary and serious risk—a risk that is not counter-balanced by any other obvious advantage.

4. The wound left after the removal of the tongue is, in a surgical sense, extremely simple, and is actually a clean incised wound. Such a wound must compare favorably with the external charred surface left after the galvanic *écraseur* and with the lacerated wound that follows the use of the cold wire. When the tongue is removed by scissors there are no superficial sloughs to come away from the floor of the mouth, and there is, therefore, less opportunity for the formation of a fetid discharge.

5. The intra-oral part of the operation occupies but a brief space of time, the actual excision requiring probably about two minutes. It is needless to say that when a patient is anesthetized a prolonged operation upon the tongue is objectionable in many ways. The cold wire, if cautiously applied for the removal of the entire tongue, will usually not have cut its way through in thirty minutes.

6. Through the incisions made in the neck the surgeon is enabled to readily remove enlarged glands, and to detect such bodies when they are not to be felt through the skin.

#### Congestion of the Brain, with Convulsions, Successfully Treated by Venesection.

Mr. Shout, of Chelmsford, writes, in the *Brit. Med. Jour.* :

"The following interesting case has just happened in my practice, which satisfactorily proves that the old disused custom of depletion is, at certain times and in properly diagnosed cases, the only available treatment; and, if judiciously employed, will most likely save life, as was evidenced by the results.

"I was hastily summoned to a young man, aged 21, who had accidentally fallen into the canal, and was supposed to be suffering from the effects of his immersion. I found, on my arrival, that his wet clothes had been changed. He lay upon a couch on his back; the surface of his body was warm; the skin dry, and in its normal condition; his breathing slow; face and neck swollen and congested; pupils semi-dilated, and which did not contract under the stimulus of a strong light; jaws firmly locked; he could not swallow, as a teaspoonful of water ran out of his mouth when given; pulse 100, slow and intermittent; and there was likewise constant spasmodic twitching of the right arm. He could not be aroused from his coma; even tickling the soles of the feet gave no indications of consciousness; there was no paralysis nor rigidity of any part of his body. Mustard plasters were applied to the front of the chest and to the nape of the neck. After a time, he became very violent, opening and shutting his mouth, forcibly protruding the tongue, and endeavoring to bite his arm, which

he seized between his teeth, and it would have been severely injured, had he not been prevented by forcible restraint, it taking several strong men to hold him down during the paroxysms; his face and neck becoming more swollen and turgid, and the convulsions more frequent and urgent every minute.

"I concluded that nothing would relieve him except free depletion, which was at once performed in the usual situation in the left arm. The blood ran very slowly at first, but after a time more freely; it was very dark-colored, which condition continued until the necessary quantity was obtained, the lips becoming blanched, and the pulse more regular. He commenced yawning, and then talking; vomited twice, bringing up some half-digested food; and upon being asked, said he 'never felt better in his life,' and wished to lie down, as he felt very sleepy. Somewhere about twenty-five or thirty ounces of blood was drawn, but the exact quantity was not known, as a common hand-basin was used for the purpose. He was put to bed, when he slept for two or three hours, after which he awoke much refreshed, and was apparently quite well. He slept well all night; and next morning came to see me, having walked about half a mile. He said he was much better, but the spasmodic twitching of the right arm still continued.

"He gave the following account: Two days previously, he had attended some races, and had been induced to drink more beer than was good for him, having been an abstainer; he had likewise been engaged in wheeling coal from a large, which he found very heavy work, not being used to it. The sun was, during this time, bright and warm, with a strong north-east wind blowing. He found, on getting up next morning, that his right arm was in continual motion; he could not hold it still. He thought he had delirium tremens; but he still continued at his work, his head feeling giddy and light, and gradually increasing in intensity; he commenced dancing about and performing other antics, not being able to control or direct his movements. He saw the water before him, and all the time thought he was moving backwards and away from it, but instead was going towards it, and into which he fell, its depth being sixteen feet. He found himself at the bottom, and everything he saw appeared enormously enlarged; he came quickly to the surface, and clutched at some reeds, and by the assistance of those present gained the bank, when he became perfectly insensible, and knew no more."

#### Nitrite of Amyl and Nitro-Glycerine in Uræmic Asthma.

In the *Brit. Med. Jour.* Dr. Sheen, of Cardiff, writes:

"The brief notes I give below illustrate the value of nitrite of amyl and nitro-glycerine in one of the sudden and distressing, though perhaps rare, phases of chronic Bright's disease, viz., uræmic asthma. Nitrite of amyl, acting, probably through the vaso-motor nerves, relaxes the arterioles, and thus reduces blood pressure. As it is very volatile, on the score of economy and convenience, I always carry some of Martindale's capsules in my bag, and these are very handy for

immediate use. Nitro-glycerine is said to have much the same action as nitrite of amyl, and, according to Dr. Mahomed, its great superiority over amyl lies in its gradual and more lasting effect, and the more convenient manner of prescribing it, and it can be taken regularly two or three times a day, or oftener, one minim of a one per cent. alcoholic solution being the usual commencing dose. It is also made up in chocolate tablets, each containing one-hundredth part of a minim; but its action, when given in this form, is not so rapid as that of the alcoholic solution.

"M. P., aged 55, retired from business May 4, 1882. Has been ailing for two weeks, but has been about. Has noticed swelling of the legs towards night for two months, and his face had swollen occasionally for the last month. Has always been careless of his health, and if he got wet, an event which happened not unfrequently, he would never change his clothes. He was taken suddenly ill last evening whilst out walking, about a mile from home, and had to be taken home in a cab. On visiting him at 10 a. m., I found him sitting up in bed, gasping for breath, countenance distressed, and of a sickly pallid hue. Pulse feeble; temperature  $98^{\circ}$ ; tongue pale and sodden; expectoration frothy, with some little blood intermixed; moist râles over the whole chest, back and front; urine abundant, clear, containing one-fourth of albumen. At 2 p. m. I found his condition and posture unchanged; he could only speak a few words before he had to stop for breath. He inhaled three minims of nitrite of amyl (a capsule broken in a handkerchief). Within a few minutes his breath was easier, and he was able to recline in bed for the first time since the attack came on, before I left the house. I then put him on nitro-glycerine, one-hundredth of a minim *ter die*.

"May 5. He was lying easily in bed, breathing quietly, and expressing himself as feeling quite well; said he was only waiting till I came before he got up. I cautioned him that his life hung by a thread, and that he could only hope to continue it by the strictest obedience:—unavailing caution. On the 6th he remained in the same condition. The next day he refused to take any more medicine, but promised to stay in the house, a promise which he did not keep. On the 16th he had another attack, and died quietly within thirty-six hours, the urine being loaded with albumen."

#### Mercurial Decalcification.

From the *Lancet*, April 14, 1883, we learn that a remarkable effect of acute poisoning by mercury, in the form of corrosive sublimate, was discovered by Salkowski, and has been confirmed by Prévost and Frutiger, of Geneva, in a very interesting investigation. The effect is the deposition of calcareous salts in the cortical substance of the kidney. The deposits of lime-salts may easily be confounded with deposits of fat. The process commences in the straight tubules, and afterwards involves the tubuli contorti, and is sometimes so great that the kidneys appear as if petrified. The effect is most marked in the rodents, but may also be observed in the cat, and likewise, although with more difficulty, in the dog, and it is apparently of the same nature in all animals. It is

very remarkable that this change is not, as might be expected, most marked when the poisoning is most chronic. It is greatest when the doses of the poison are such as to cause death in three or four days, and are too small to kill within four-and-twenty hours. The Swiss investigators have made a very important discovery as to the process by which this remarkable effect is produced. They find that the calcification of the kidneys is accompanied by, or rather accompanies, a removal of lime-salts from the bones which, in the case of rabbits, is sufficient to render the epiphyses of the long bones movable on the shafts. In order to estimate the actual amount of decalcification, a series of comparative analyses were made, the tibia being the bone chosen. The loss of lime was found to be usually from two to four per cent., and sometimes to amount even to eight or ten per cent. The change in the bones was always inversely proportioned to the change in the kidney. To obtain even more precise results, the leg of one animal was amputated before the commencement of the experiments, so that the normal proportion of lime-salts might be accurately compared with that present after the action of the corrosive sublimate. But the result of this experiment was the demonstration of a very interesting fact in relation to the processes of calcification and decalcification in the system. It was found that when the animal had recovered perfectly from the effect of the amputation, no mercury having been given, there was an increase in the amount of lime in the opposite tibia. Even after intoxication by mercury, it was found that there was still an excess of lime present, showing that the augmentation due to the amputation of the other leg was more than enough to compensate for the loss produced by the mercury. The peculiar effect of the corrosive sublimate cannot be attributed to impairment of the general nutrition, since in starving animals, which had lost 800 grammes of body weight, the proportion of the mineral constituent of the bone was positively increased instead of being diminished. The rapid decalcification of the bone seems to afford an adequate explanation of the accumulation of lime-salts in the kidneys, arrested in the process of elimination by these organs.

#### Beri-Beri.

The *Lancet*, April 21, 1883, tells us that the very fact of limitation to a certain part of the surface of the globe lends to the inquiry into the nature of such diseases as beri-beri a suggestiveness which has unfortunately not yet been productive of commensurate results. The relations of beri-beri with other maladies have long been the subject of dispute, and the final solution of the question cannot be said to have been advanced by the most recent contribution to the study of the disease by M. Durodié. The central factors which go to make up the clinical picture of the disorder are anæmia, oedema, and numbness, with paralysis, chiefly affecting the inferior extremities. The disease may run an acute course, or the tedium of its symptoms may be felt over a long period. The profound and rapid anæmia has suggested to many German writers the question of the affinity of the malady with progressive pernicious anæmia. But it seems cer-

tain that we have to do with something more than an idiopathic anemia, and it cannot be said that the association with the progressive pernicious variety would do anything else than render the disease more obscure. The edema would seem to have somewhat special characteristics; it is of rapid onset and of wide extent, and in the final stages dropsy of all the serous cavities, but more especially of the pericardium, has been observed. The stiffness with numbness and palsy of the legs are also strongly marked features. It appears that a residence of more than six months in places where beri-beri is endemic is necessary for the due appearance of the disease. The imbibition of much brackish water also seems to play a part in the causation. The increase of the number of cases in galls at the end of the rainy season is a remarkable fact, the full explanation of which would probably cast much light on the etiology, as would also the complete *rationale* of the limitation of the remarkably fatal disease to a littoral band of about fifty miles in breadth. The alliances of beri-beri with disorders of the nervous system and with the malarial fevers are also considerable. The disease has been studied more by English than other physicians, and the majority seem to have regarded the affection as an essentially constitutional disorder; and even the most competent of those English observers do not seem to think a more differentiated opinion of the nature of the pathology is possible in the present state of our ignorance.

#### Some Effects of Nasal Polypi in Children.

A. Jacobi, M. D., in the *New York Medical Journal*, April 7, 1883, relates several cases of obstinate asthma or emphysema in children. The first case was under treatment for some time before the nasal polypus was discovered and removed, when improvement immediately set in. In the second case the nose was examined, a polypus removed; another made its appearance, which was also removed; only ten paroxysms occurred since the removal of the polypi, and these are of a mild type.

"What is the explanation of the relationship existing between the presence of the nasal polypi and the asthmatic attacks, if any such exist?"

It is well known that the presence of any irritation of a mucous membrane will produce effects even at a distance; not a small number of cases of prolapse of the rectum are due to the presence of a polypus situated either upon the sphincter or high up in the rectum.

We often see nasal catarrh coexisting with enlarged nostrils—treatment of the latter curing the former; it is, in fact the result of reflex action.

The doctor also speaks of the relationship between asthma in the adult and the presence of nasal polypi.

Chorea minor, he says, is due almost exclusively to a local irritation of the mucous membrane, associated with chronic nasal pharyngeal catarrh, the chronic symptoms becoming aggravated during acute exacerbations of the catarrh. An intimate relation exists between the nervous system and the nasal mucous membrane; the trigeminus, with all its branches, is subject to direct or reflex irritation, arising from inflamed condition of the nasal mucous membrane.

The thickened mucous membrane or a polypus, in the narrow nasal passages of a child, would seriously interfere with respiration, and hence an accumulation of carbonic acid gas in the brain, particularly about the respiratory centre at the medulla.

The lymphatic system of the nasal mucous membrane and that of the dura mater and the arachnoid membranes are in intimate relations with each other. It will be seen that good reasons have been advanced to show the intimate connection between diseases of the mucous membrane of the nose and cerebral affections.

#### The Effect of Noise on Healthy and Diseased Ears.

Dr. D. B. St. John Roosa read a paper on this subject before a recent meeting of the New York County Medical Society (*Boston M. and S. Jour.*, May 3, 1883), in which he summed up his experiments somewhat as follows:

(1) A large class of persons suffering from deafness can hear quite distinctly when in a noise.

(2) When this is the case, the disease is situated in the middle ear. The disease is usually of a chronic, non-suppurative character; but the same phenomenon is also noticed sometimes in acute and subacute affections of the middle ear.

(3) The proximate cause of this is not yet definitely determined, but it is believed to depend on the condition of the ossicles.

(4) Boiler makers' deafness is of an altogether different character from the above.

(5) The latter is believed to be due to disease of the labyrinth or the trunk of the acoustic nerve.

(6) Those suffering from boiler makers' deafness do not hear better in a noise.

(7) Cases of impacted cerumen and other affections of the external and middle ear occur in boiler makers as well as in other individuals.

(8) In disease of the labyrinth the tuning-fork C is heard louder and longer through the air than through the bones of the head.

## REVIEWS AND BOOK NOTICES.

### NOTES ON CURRENT MEDICAL LITERATURE.

—Two publications on the opium habit are worth the attention of those who would study this form of slavery. One is "Clinical Notes on Opium Addiction," by Dr. J. B. Mattison, of Brooklyn, N. Y.; the other is on the successful treatment of the habit by the *avena sativa*, by Dr. E. H. M. Sell. That a tincture of common oats should turn out to be, as Dr. Sell asserts, "the very best remedy in the distressful, and in many cases, hopeless, malady of the morphine or opium habit," is indeed remarkable.

—Dr. E. E. Montgomery, of this city, in a recent reprint argues against the justifiability of craniotomy on a living child. His presentation of his side of the argument is forcible.

—Of pharmaceutical reprints, the "Review of the Drug Trade of New York for 1882," by Mr. D. C. Robbins, of New York, and a discussion of the question: "Is there a necessity for Pharmacy Acts?" by M. G. J. Seabury, are excellent papers.

—The *Inter-Change* is a monthly published by Howard Challen, Philadelphia, the purpose of which is to give all sorts of information concerning books relating to, and periodicals publishing, articles on special subjects. Medicine and hygiene come within its domain. Subscription, \$1 a year.

—A reprint on the "Medico-Legal Relations of Insanity," by Dr. Ira Russell, of Winchendon, Mass., deals largely with the question of insane criminals.

—At the last commencement of the National Medical College, Washington, D. C., addresses were delivered by Prof. A. F. A. King and Dr. Philip G. Wales, U. S. N. These have been published in neat pamphlet form.

—Under the editorship of Dr. Romaine J. Curtiss there has been commenced at Peoria, Ill., a monthly entitled *Home Health*. It is a popular journal on hygiene and sanitary science, and contains original articles and selections. It looks well and promises well, and we hope for it a prosperous career. Price, \$2 a year.

—Dr. G. Reck's "Therapeutischer Almanack" for 1883 contains its usual condensed summary of information on this branch (J. Dalp, Bern, 1883).

#### BOOK NOTICES.

**Brain-Rest.** By J. Leonard Corning, M. D. New York. G. P. Putnam's Sons. 12mo. pp. 103.

By "brain-rest" Dr. Corning means *sleep*, and he discusses its vast importance and the means by which it can be obtained. He speaks especially of the value of compression of the carotids as a means of reducing the cerebral circulation, and describes and figures an apparatus he has invented for that purpose. The essay is an ingenious and suggestive one, and merits a careful perusal.

**The Microscope and its Revelations.** By William B. Carpenter, C. B., M. D., LL. D., etc. Sixth edition. Illustrated. Vol. I. William Wood & Co.

This is the April number of Wood's Library of Standard Medical Authors. It is profusely illustrated, and by an author who always writes both

in an agreeable style and with a full knowledge of his subject.

**A Treatise of Practical Instructions in the Medical and Surgical Uses of Electricity.** By L. E. Morrill, M. D. Kalamazoo, Mich.

The author of this work is an enthusiast for the miscellaneous and universal uses of electricity in therapeutics. It is lacking in critical judgment, and will be sure to bring about disappointment in those who proceed confidently in many of its recommendations. Nothing is gained to science by lauding electricity as a panacea, or exhibiting it to the exclusion of other modes of cure. The volume seems to be aimed for general perusal, rather than professional, and if so will create in readers hopes of alleviation often doomed to be blasted.

**Alcoholic Inebriety from a Medical Standpoint.** With cases from Clinical Records. By Joseph Parrish, M. D. Philadelphia: P. Blakiston, Son & Co, Pp. 185. Price \$1.25.

Few individuals have given such close attention to the study of inebriety as Dr. Parrish. With him it has been the main interest of his professional life. His matured views, as they are presented in this work, must command the close consideration of all who would solve or try to solve the hideous enigma of intemperance.

Evidently the author leans strongly to the belief that in very many cases persistent drunkenness is a disease which must be treated, and may be cured, as are other diseases. On one point we could wish he had been more definite. The distinction between inebriates and moderate or even "heavy" drinkers is not clearly drawn, and hence many of the statistical assertions are less accurate than they might be.

The subjects discussed are, who are inebriates, inebriety a disease, traumatic and hereditary inebriety, the relations of inebriety to insanity, inebriate asylums, their management, the different alcohols and their effects, and the psychology of inebriety. On all these the reader will find excellent material and carefully digested observations.

—A man went into a drug store, and asked for something to cure a headache. The druggist held a bottle of hartshorn to his nose, and he was nearly overpowered by its pungency. As soon as he recovered, he began to rail at the druggist, and threatened to punch his head. "But didn't it help your headache?" asked the apothecary. "Help my headache!" gasped the man. "I haven't any headache. It's my wife that's got the headache."



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KATATONIA.

By this term is to be understood, so Dr. Wm. A. Hammond says in the *N. Y. Med. Jour.*, May 5, 1883, a form of insanity first described by Kahlbaum, and characterized by alternate periods supervening with more or less regularity, of acute mania, melancholia, and epileptoid and cataleptoid states, with delusions of an exalted character and a tendency to dramatism.

Several cases from his practice are cited.

A merchant presented the first symptoms by a condition of exaltation; he entered the office with all the air of a prince, and answered all questions by repeating in a supercilious way, "And the Lord spake unto Moses, saying." This he repeated during the entire visit. By inquiring I learned, however, that eight days previously, without any assignable cause, he had passed into a condition of melancholia, with stupor. By extending his arm at right angles to his side, it was noticed that it remained in that position for thirteen minutes, and then descended slowly to his side. Ophthalmoscopic examination being demanded, the patient would not enter the dark room. Upon endeavoring to carry him there, he at once became as rigid as a bar of iron—his muscles were in a state of extreme tension.

The next case, a young German, exhibited the cataleptoid state, and a tendency to utter high-flown language, and to assume histrionic attitudes, exclaiming at intervals, "My lord, it shall be done!" He had passed through the stage of melancholy before presenting himself.

He frequently cried and groaned, said afterwards that the reason he did not speak was because he had the idea that it had been decreed that if he uttered a single word, his mother would at once die.

The third case was a physician. When seen he was in the stage of melancholia with stupor, attended with cataleptoid symptoms. If physical efforts were used, his whole muscular system was thrown into extreme tension. He appeared to be in a condition not unlike a person suffering from tetanus. Another case, a Swede, age 30, presented much the same symptoms as the former cases.

The doctor says that many cases of unrecognized katatonia are to be found reported in writings on psychological medicine.

The disease is more common in men than in women.

"Katatonia is of rather favorable prognosis. It appears in the first stage, at least, to be a vasomotor affection characterized by a paralysis of the vascular coats, and by consequent cerebral hyperæmia."

All his cases except one yielded readily to the bromide of sodium; that patient did not get the medicine prescribed.

#### ANCIENT ROME AND THE CAMPAGNA.

Dr. Drummond, of Rome, recently delivered a lecture before the British and American Archæological Society of that city, on the "Climate of Ancient Rome," in which we have the same old story told again.

*Unused organic remains producing disease.*

From the historical fields of ancient Rome, as from our own new country, comes ever forth the imperious mandate, *unto dust thou must return*, not figuratively, but absolutely.

From these soul-stirring campagnas, we read the same lessons that sanitarians of to-day are teaching.

Dr. Drummond very sensibly argues that the ancient Romans must have been a healthy race, else their wonderful physical achievements would have been impossible; and with equal reason he concludes that this health was due to their belief in hygiene and sanitary matters; to their athletic sports and their unparalleled baths.

The malaria of the campagna, he attributes to systematic neglect of proper drainage and cultivation.

Here it is again: the old lesson.

This campagna was once thickly inhabited with organic life; it died, and for centuries has been lying, decomposed and unused, save to poison the atmosphere. The experiments or experience within a short time of the Trappist monks, who are cultivating certain portions of the campagna,

is that they have rendered their vicinity free from atmospheric poison.

Does not this experience teach us, that the rotatory life of atoms is an essential to healthy surroundings; from vegetable life, directly, as well as indirectly, through the lower animals to man, and from man back to the vegetable kingdom and so on?

Any interference with this rotation, any delay on the part of these elements, in their journey, renders them more or less inimical to healthy animal life, since it disarranges the beautiful economy of nature.

Let us learn the lesson, and ponder well over it.

#### L' HOPITAL DES ENFANTS ASSISTÉS A PARIS.

A very interesting report on this large and important institution was recently presented to the *Ministre de l'Interieur* by MM. Lunier and Foville.

This hospital admits from five to nine thousand children annually, but as many of them remain but a short time in the institution, from twenty to thirty are admitted or discharged daily. Usually there are from 350 to 400 children in the hospice. The ages vary from a few days to twelve years or over. In 1881, 1,758 under one month old were admitted, 906 from one month to one year, and 1,628 from six to twelve years old. The *Enfants-Assistés* are children presented by their families to be abandoned (*à la Jean-Jacques Rousseau*), and others found in the streets or left in the hands of nurses. Another class, the *Enfants-Secourus*, are children at first abandoned by their parents, but returned to them with a small government allowance to enable them to bring them up.

The commissioners very warmly recommend isolation of contagious diseases, which is impossible in the present condition of the hospice. According to M. Lunier, one-third, at least, of the children who die in the institution contract in the wards the contagious disease to which they succumb. Diphtheria is so prevalent and so malignant as to have caused the death of two very distinguished *chefs-de-clinique*, who were obliged to make direct applications to the throat.

An unique feature of the institution is the

nursing service for syphilitic infants, established by M. Parrot. The nurslings draw their nourishment directly from the teats of the ass, to which they are presented five times during the day and three times at night. They thrive under this treatment, and 70 per cent. live, while almost all formerly died when fed from the bottle.

#### COLD BATHS IN TYPHOID FEVER.

In the recent lengthy and desultory discussion on the treatment of typhoid fever in the French Academy, the method by cold baths provoked considerable discussion.

Prof. Bonley was the defender of Brand's method, bringing forward in support of his views statistics obtained through the French ambassador at Berlin. M. Ricklin has since reviewed the statistics obtained, and arrived at the following conclusions:

Brand claims that the average mortality before the introduction of the refrigerant treatment was as high as twenty-one per cent., and that under the influence of this method it has fallen to seven per cent. In support of this assertion, in the last edition of his work (*Die Wasser Behandlung der Typhösen Fieber*, 1877,) he gives statistics founded on 355 cases observed in his own practice, with fifteen deaths, an average mortality of less than five per cent.

But on consideration of the cases we find that 211 occurred in his private practice without a single death; so that among the remaining hospital patients, 124 in number, fifteen deaths took place, making the real mortality in the cases adjoined by Brand twelve per cent.

Closer examination of the statistics presented by the German authors in support of this method, show that the average mortality in Schmidt's service at Erlangen was nineteen per cent.; in the Rudolph Hospital, at Berlin, from fifteen to thirty per cent.; in the Bethany Hospital, where the method was systematically carried out by M. Goldammer, from ten to sixteen per cent.; in Stricker's service, seventeen per cent., and so on in all the hospitals of Berlin where this method of treatment was most rigorously carried out.

#### NOTES AND COMMENTS.

##### Irregular Contractions of Uterus a Source of Danger After Labor.

In the *Med. Times and Gaz.*, April 28, 1883, Dr. William Alexander calls special attention to this condition, and indicates its dangers and its relief with the following cases:

"Some years ago a patient in the lying-in wards had my attention called to her three days after delivery on account of her feverish and restless condition. I found a firm round tumor in the right iliac region, about the size of an adult human head. It was very tender, and was freely movable. Next day peritonitis had set in, and the tumor was much less distinct. Poultrices were used, and the usual treatment of those days, but the patient died. The uterus had contracted irregularly, and had become tilted into the iliac fossa, so that drainage could not be carried out. About six months ago I saw a similar case in private, accompanied by much fever and such an appearance of the patient that the ordinary medical attendant thought it was "all up" with her. Having by this time unraveled the true pathology of such cases, I grasped the uterus gently, and by gradual pressure caused it to contract and to expel a considerable quantity of discharge. A little pain was produced at first, but this soon subsided, and before I left the house the patient expressed herself as much relieved. In the first case, the old treatment—poultices to the abdomen, sudorifics, anti-pyretic vascular sedatives were used—remedies that I believe increased rather than diminished the mischief. Antiseptic syringings of the uterus and vagina are the only rational treatment hitherto employed; but these syringings were rarely complete, and seldom passed beyond the vagina. The amount of pressure must be reasonable, for harm might be done by doing too much, and practically is rarely required in my hospital practice, because of the efficient way in which the binder is applied. Its application is, I believe, one of the most important subjects in midwifery, and it is applied by my nurses in the following manner: The uterus is first ascertained to be well contracted, and at least in the entrance of the pelvis. A broad and substantial pad is applied over that organ, and kept in its place by a strong twilled calico binder that reaches from the great trochanters to the eighth or ninth ribs. This binder is drawn as tight as the patient can bear with comfort, and is watched, and readjusted if necessary several times in the day. I make it my business to see that

the binders are properly applied, the patients and napkins clean, and the wards pure. Nothing else requires to be done except to pass my hand over the abdomen, generally outside the binder, in a small percentage of cases who show high temperature."

#### An Inquiry into the Causes of the Increase of Cancer.

At the end of a long and elaborate thesis on this question, Mr. Dunn concludes (*Brit. Med. Jour.*):

"1. That, in the face of incontrovertible facts, cancer is increasing in England.

"2. That this increase is due (a) To the success attending the legislative measure and other means for the preservation of the infant population, by which a large proportion of persons reach adult age, and the general healthiness of the community is increased. (b) To the greater prominence which, in the present day, prevails, of the most predisposing causes of the disease—such as the fecundity of women, the prevalence of high nervous tension, the existence of possibly greater general luxury in the mode of living.

"3. That the immunity apparently demonstrated by the records as present in certain counties of England and Wales, is presumably, as we have attempted to show, not due to any real declination of the disease, but rather to such causes as can be explained by special local predisposition to other diseases, to which a large proportion of the adult population succumb.

"4. That in consequence of this, if each district of England and Wales were equally healthy, each would probably exhibit a high cancer mortality.

"5. That the geographical area of which England and Wales is composed, is insufficient to account directly for interruption in the distribution of cancer as met with in this island."

#### Alcoholism a Cause of Sterility.

In the course of the Gulstonian Lectures on Sterility (*Brit. Med. Jour.*, April 21, 1883), Dr. J. Matthews Duncan attributes a causative influence to the free use of alcohol. He says, "The immoderately great consumption of alcoholic drinks by women, without their necessarily ever reaching the stage of drunkenness, is so common and so potent a cause of disorder and disease, that it requires special mention. It is possible that much of the influence of this drinking might be justly ranked as part of mere overfeeding, whose injurious effects we have already spoken of; but this is

far from certain. Indeed, while I am unable to give any strong evidence of the specially injurious action of alcohol, considered as an article of diet, I am much disposed to this view, being led to it by the good results in practice which I believe justly attributable to desisting from the use of it. But alcoholic drinking has, in addition to the general or constitutional disorder which it produces, well ascertained power, in certain cases, to induce disease of the internal genital organs. That which is most easily and distinctly made out is chronic ovaritis. It often comes and goes in the presence or absence of the cause. When it is present, sterility is not always a result, but frequently so, and its cure is often followed by the disappearance of the sterility."

#### Presence of Phosphate of Magnesium in the Urine of Persons suffering from Affections of the Stomach.

A man, æt. 49, suffering from a chronic affection of the stomach (dyspepsia, constipation, frequent vomiting), discharged urine which was free from albumen and a sediment, but was alkaline, and whose reaction was caused by a fixed alkali. Letting the urine stand for five days in a warm room had not made it ammoniacal as yet, but there now appeared a sediment of transparent crystals (four-sided prisms), which by their shape, as well as by their reaction to carbonate of ammonia (opaque and stripes, especially in the longitudinal direction) proved themselves to consist of phosphate of magnesium. Such a sediment formation out of an alkaline urine (whose reaction in this case was caused by frequent vomiting and the abstraction of acid from the system necessarily connected with it) seems to be very rare, and to happen then only, when after letting the urine stand for a number of days, the decomposition of urea into carbonate of ammonia, and the formation, connected therewith, of phosphate of ammonia—magnesia has not taken place. As the occurrence is so rare, and can be caused only under the circumstances mentioned, it may be possible that the fact, by further investigations, may become an important one in the always difficult diagnosis of certain obscure diseases of the main organ of digestion. (*Deutsch Arch. of Klin. Med.*, xxxi., p. 203.)

#### Lacerations of Cervix Uteri.

Dr. Mary A. Smith contributes to the *Boston Med. and Surg. Jour.*, April 5, 1883, the statistics of operations for this accident occurring in the New England Hospital for the two years beginning October 1, 1880. Only such cases are reported as



were of sufficient gravity to require surgical interference. There were forty cases, fifteen in primiparæ and twenty-five in multiparæ. Thirty-seven were operated upon thirty-nine times, three yielding to non-surgical treatment.

## SITUATION OF THE INJURY.

On the right side . . . . .	1
On the left side . . . . .	8
Bilateral . . . . .	28
Stellate . . . . .	3

Total . . . . . 40

## CHARACTER OF LABORS IN WHICH THE LACERATIONS OCCURRED.

Rapid . . . . .	16
Tedious . . . . .	7
Difficult . . . . .	3
Forceps used . . . . .	8
Unknown . . . . .	6

Total . . . . . 40

The after treatment consisted in rest in bed and confinement of bowels for one week. Stitches removed on tenth day, unless menstruation had occurred, when they were left until fourteenth day. In ordinary cases patient began getting up after two weeks.

## RESULT OF OPERATIONS.

Perfect union . . . . .	33
Partial union . . . . .	4
Secondary operations . . . . .	2

Total . . . . . 39

## An Explanation of Inhibited Development.

## A Case of Perobrachy Explained.

A railroad laborer, æt. 40, who was fatally injured by an accident, and who had been affected all his lifetime (being born that way) with a want of development of his right lower arm and hand, gave Dr. L. Davida (Centrbl. f. d. Med. Wiss., 48, 82, p. 879) a good opportunity of studying the morbid condition of his nervous system accurately. D. found that from the sixth cervical nerve to the first thoracic nerve, the anterior as well as the posterior roots contained a decidedly smaller number of nerve fibres on the right than those on the left side. The spinal ganglia on the right side were also smaller than those on the left, and the anterior branches thinner than on the healthy side.

The explanation would seem natural, that this condition of things caused the perobrachy. This is the opinion of Davida. But we believe that in the brain the real cause would have been found. The abnormal condition in the spinal cord simply showed the same status which we always find whenever an extremity, or a part of one, or a

muscle, or a set of muscles, has not continually exercised its normal function. In such cases, the spinal origin of the respective nerves becomes atrophied, dwindles away. Why would we find such lesions in persons who all their life had a perfect use of their limbs, and who some years before their death were by an accident, or by paralysis, or amputation, deprived of their use?

## Hæmorrhage from the Lachrymal Duct During Epistaxis.

Mr. D. Hoadley Gabb, M. R. C. S., of Hastings, describes the following remarkable case in the *British Medical Journal*:

"Mr. S., aged 50, with mitral disease and albuminuria, sat out one of our recent sunny days, and caught a chill, which culminated in an attack of bronchitis and a relaxed state of the fauces and uvula, producing severe spasmodic cough; during one of these paroxysms, epistaxis, from the right nostril especially, came on rather profusely, and I was sent for. There was no difficulty in arresting it by plugging the anterior nares with dry lint. In two or three hours, after a severe cough, the hæmorrhage returned, and a messenger was sent for me, saying the bleeding had come back, and was running out of his nose and eyes; and so I found that the blood had welled up through the right lachrymal duct, and was suffusing his eye, so that he was constantly obliged to wipe it, and the handkerchief was pretty well stained with the blood, and the discharge only ceased when the nose left off. I have never met with the phenomenon before, neither have others to whom I have mentioned it; and so, I think, perhaps it is worth recording."

## The Treatment of Parturition and the Parturient State in Hospital Practice.

Commenting on the fact that nature unaided deals much more leniently with the parturient woman, at any rate among the lower classes, than when she is aided by the highest medical skill and with all the appliances of hospital treatment, Dr. William Alexander, in the *Medical Times and Gazette*, April 7, 1883, raises his voice against meddling midwifery. He deprecates unnecessary examinations, lest our fingers may introduce septic material, and urges us to give nature a fair chance to expel the placenta before we interfere. He again urges cleanliness as the great desideratum, and considers that the proper kind of a bed for a lying-in hospital is one made of clean straw, retained in an easily-washed sack of coarse ticking; a double blanket will make it sufficiently soft. At

the end of twenty-four hours the patient is transferred to the lying-in bed, another new straw bed of larger dimensions. This the patient occupies for a week, when she is transferred to another new bed in the convalescent ward. The ticks are thoroughly washed, and the same straw is never used twice in the *lying-in wards*. From these suggestions we can derive some hints for our guidance in private practice.

#### Lister and the Spray.

Dr. Henry Gray Croly publishes the following letter from Mr. Lister on this subject in the *Medical Press*, April 25, 1883:

"I have not given up the use of the spray, although I certainly regard it as the least important part of our antiseptic arrangements. Whatever other good it may do, it is a very mild form of antiseptic irrigation, and tends to keep the *entourage* of the wound, including the surgeon's hands and instruments, pure. But if I had not a spray-producer at hand, I should not on that account omit other elements of antiseptic treatment. I still use the spray in changing dressings, so long as the wound is not merely superficial. But far more important than using the spray is it to make a point of covering the wound with some pure aseptic material before beginning to wash the parts which were covered with the edge of the dressing only, and were, therefore, impure. In other words, I believe one of the commonest causes of failure is dabbing alternately the impure surrounding parts and the pure wound with the same piece of rag, which, though moistened with carbolic lotion, cannot work miracles."

#### Compound, Comminuted Fracture of Skull; Trephining; Recovery.

Dr. A. D. Murray reports a case in the *Lancet*, April 28, 1883. The operation was performed in the usual way. A little more than half a circle was removed from the sound bone above the apex of the triangular depressed portion, and after a corner had been removed by means of the saw, the piece was easily lifted out; a clot was found under this. The middle meningeal could be seen pulsating at the lower corner, but was uninjured. Some fragments were taken away, the wound dressed with carbolic oil and washed frequently with carbolic spray. The man made an excellent recovery, never having had a bad symptom.

He thinks that this case points strongly to the advisability of trephining at once in compound comminuted depressed fracture of the skull, without waiting for symptoms of compression.

The operation does not add to the patient's danger, and may, in all probability, be the means of preventing serious complications.

#### Sub-periosteal Amputation at Hip-joint.

Before the Clinical Society of London (*Medical Times and Gazette*, April 14, 1883), Mr. Howard Marsh read the report on Mr. Shuter's case of subperiosteal amputation at the hip-joint which was signed by Messrs. Croft, Marsh, Clement, Lucas, and Shuter. The report went to show that it was doubtful whether any amount of bone was present in the central cord of firm resisting tissue, that it was true that the muscles were in a high state of nutrition, and were able to give the stump and an artificial limb independent motion. The committee also decided that in the operation performed there was diminution in the risk from hæmorrhage, with preservation of muscles of such a length as would correspond to that obtained by an amputation through the upper third of the thigh; it was also found that the periosteum had been stripped off as high as the trochanters.

#### The Coat-Sleeve Amputation.

Some time since we referred to this operation of Mr. Davy's (*Brit. Med. Jour.*, June 17, 1882), in which a circular incision is made, the tissues dissected up, the bone sawed through, and the tissues brought together as one would the end of the coat-sleeve. Dr. L. Colbourne, of Buenos Ayres, writes to the *Brit. Med. Jour.*, April 7, 1883, that having occasion to amputate the leg of a fairly muscular man, he found it impossible to turn the tissues up, when the diameter of the leg was (as in robust people, it always will be) greater above than at the point of incision. To obviate this difficulty, he made a longitudinal incision in the posterior aspect of the flap.

#### The Deligation of Large Arteries by the Application of two Ligatures and the Division of the Vessel Between Them.

Attention is called by Dr. W. J. Walsham, in the *Brit. Med. Jour.*, April 7, 1883, to the fact that secondary hæmorrhage, after ligation of arteries, is often due to the fact that in separating the sheath from the artery, the blood supply of the latter is cut off, and sloughing or gangrene of the vessel in the vicinity of the ligature results. To obviate this danger he recommends applying two ligatures, about half an inch apart, the denuded and devitalized portion of the vessel being thus between them, and dividing the vessel in this portion.

**The Benzoates in the Uric Acid Diathesis.**

In the course of the Lumleian lectures on uric acid, Dr. Alfred Baring Garrod states (*Brit. Med. Jour.*, April 21, 1883), that the Benzoates possess the power of causing the disappearance of uric acid from the urine. He frequently uses benzoate of sodium, and if at the same time he desires to increase the quantity of the urinary secretion, he gives the benzoate of potassium or lithium. He is directing his researches towards the formulating of some food sufficiently rich in hippuric acid as to keep in check the tendency to form and deposit uric acid.

**Salicylic Hair Tonic.**

A correspondent of the *Druggists' Circular* recommends the following as the best remedy against dandruff, itching of the scalp, and falling of the hair:

Borate of soda . . . . .	10 drachms.
Salicylic acid . . . . .	10 scruples.
Tincture of cantharides . . . . .	6 ounces.
Bay rum . . . . .	25 "
Rose water . . . . .	25 "
Boiling water, enough to make . . . . .	4½ pints.

Dissolve the borax and the acid in boiling water; mix the bay rum and rose water with the solution; then add the rest, and filter.

**Spasm of Eyelids and Ciliary Muscles with Intense Pain, Caused by Exposure to Electric Light.**

Dr. A. T. Thomson reports in the *Med. Times and Gaz.*, April 14, 1883, the case of a man aged twenty-five, who on two different occasions neglected to wear his eye-protectors when working about an electric light. In both instances, some three hours after the exposure, violent pain, so intense as to prevent sleep, came on in both eyes, and he lost control over the eyelids, which remained rigidly closed. Free instillation of solution of atropine gave prompt relief.

**Balano-posthitis of Diabetics.**

For this trouble Prof. Simon specially recommends cleanliness, and after each micturition, lotions feebly charged with phenol, and after drying the part, powdering it with the following:

R. Oxide of zinc . . . . .	25 parts.
Starch . . . . .	25 parts.
Salicylic acid . . . . .	1 part.

M.

**Iodine for Vomiting.**

Dr. T. T. Guant (*American Journal of the Medical Sciences* for April, 1883,) has for a number of years been employing the compound tincture of iodine in drop doses in nearly all forms of emesis,

and reports thirteen cases of the most varied character, in all of which vomiting was promptly arrested by its use.

**Oxide of Zinc in Chronic Diarrhoea.**

M. Gubler has found it most useful in the diarrhoea of phthisis, and whenever ulceration of the uterus is suspected. He gives it in powders in the following form: Oxide of zinc, thirty grains; bicarbonate of soda, ten grains; in four powders, two or three daily.

**Fatal Shock from Supposed Snake Bite.**

That imagination may prove fatal, receives fresh proof from the case reported in the *Med. Press*, April 25, 1883, by Dr. C. R. Francis. The patient, awakened from his sleep by something creeping over his naked legs, immediately jumped to the conclusion that it was a cobra, went into a state of collapse, and died, though it was discovered, even before death, that the supposed cobra was a harmless lizard.

**Salicylic Acid for Venereal Warts and Ulcers.**

Dr. Solon D. Stone (*Boston M. and S. Jour.*, April 26, 1883), has had very good results. His method is to fill, or pack, an ulcer with the acid which he keeps constantly applied until there is a healthy granulating surface. For a few minutes following the application of the acid to a raw surface the pain is quite severe, but it soon subsides.

**Occlusion of Vessels by Oil.**

Dr. Handfield Jones believes (*Brit. Med. Jour.*, April 21, 1883), that in atheromatous conditions of the small vessels of the brain, and presumably also of other organs, the degeneration of the patches of atheroma lead to the formation of oily masses within the lumen of the vessel, and so to obstruction.

**Incision into and Drainage of the Pericardium.**

Dr. Samuel West has performed this operation for the first time in England in a case of purulent pericarditis. The *Med. Times and Gaz.*, April 28, 1883, tells us that it was a great success; there is no deformity of the chest, and only a very small scar remains.

**Hamamelis in Varicose Veins.**

Dr. J. H. Musser has procured good results in a number of cases of varicose veins from the use of fluid extract of hamamelis in teaspoonful doses. The cases are recorded in the *Medical Times*, April 21, 1883.

## CORRESPONDENCE.

## Pepsin Preparations.

EDS. MED. AND SURG. REPORTER:—

I have this day tested a specimen of Dr. Jensen's so-called "crystal pepsin," with the following results, which may be of interest to your readers:

*Experiment 1.* One-quarter of a grain of Jensen's pepsin dissolved in f. 3 iss. of water mixed with f. 3 ij. of water containing 9 drops of hydrochloric acid, and kept at a heat varying from 100° to 110° F., dissolved 125 grains of hard-boiled white of egg in two hours.

*Experiment 2* was an exact copy of the first, except that solution was effected in two and a quarter hours.

*Experiment 3.* One-quarter of a grain of the same pepsin, under like conditions, dissolved 150 grains, or 600 times its weight, of coagulated albumen, in about three hours—this amount of albumen being rather more than half that usually found in an egg of average size.

*Experiment 4.* One-quarter of a grain of the pepsin similarly tested with 200 grains of boiled white of egg, left a small residue (estimated to weigh 20 or 25 grains) at the end of three and a half hours, when the experiment was interrupted. It was therefore probably capable under these circumstances of dissolving at least 700 times its own weight of freshly coagulated albumen.

The solvent power of this pepsin is thus shown in these investigations of mine to be not less than twelve times as great as that of the "pepsinum saccharatum" (U. S. Pharm. 1880), and hence this method of preparing pepsin unquestionably places within the reach of physicians a vastly improved means for aiding the stomach digestion of nitrogenous foods.

JOS. G. RICHARDSON, M. D.,

Prof. of Hygiene in the University of Pennsylvania.  
Philadelphia, May 16.

## NEWS AND MISCELLANY.

## American Laryngological Association.

The Fifth Annual Congress of the American Laryngological Association was called to order in the hall of the New York Academy of Medicine, at 10 o'clock, on Monday, May 21, by George M. Lefferts, M. D., President of the Association.

After delivering his annual address, the President, Dr. George M. Lefferts, read a paper detailing new facts in laryngology.

S. W. Langmaid, M. D., of Boston, called attention to a common form of vocal disability resulting from pathological processes, the phenomena being used to demonstrate the falsity of one system of voice training. He had observed a class of patients who are in the habit of making considerable use of their voice, who complain that at a certain point in singing the scale a break occurs in their voice; below this their normal tones are preserved. He attributed this condition to fatigue of the vocal apparatus, caused by fatigue following over-exertion. It not infrequently results from sudden cessation of singing

after excessive use of the voice, and is more likely to occur in those filling a leading rôle than in the subordinate parts.

A paper on the

## DESTRUCTION OF NASAL POLYPI BY CHROMIC ACID

was read by Frank Donaldson, M. D., who said that the object of treatment in cases of mucous polypi is to remove the growths with as little discomfort as possible, and to prevent their return. Of the three methods in use—evulsion, abscission, and the electric cautery, each had its advocates and its advantages, and each its disadvantages. Evulsion causes pain, and is often inefficient to prevent their return; the removal by the snare or wire loop is open to the same objection, unless the origin of the growth is cauterized, or part of the underlying structure, including the bone, is removed, as recommended by Mackenzie. Of the caustics, in his experience, chromic acid deserved the preference. His manner of employing it is to protect the surrounding mucous membrane with a lead solution, and part of the paste is then taken up on a glass rod and buried in the polyp, which shortly afterward dries up, and is easily removed with the forceps or snare. With chromic acid we can touch the exact point of origin of the growth; and it is useful in both forms of polypi, in gelatinoid and adenomatous. In the fibrous polypi it is less efficient, because they extend frequently to the naso-pharyngeal cavity. It is not intended to substitute chromic acid for surgical procedures, but it is effective as an aid to them, facilitating their action by destroying the substance of the neoplasm, by making the operation less painful, less bloody, and by supplementing their action in destroying the insertion of the growth, and thus preventing their reformation.

Dr. F. I. Knight, of Boston, then read a paper on

## CHOREA LARYNGIS,

in which he first directed attention to the close relation existing between chorea and hysteria. The object of the paper was to call attention to the different kinds of cases which have been reported as chorea laryngis, and to invite discussion upon the same. Chorea laryngis was probably but one of the many manifestations of a general affection. There were three varieties which had been described. First, that in which not only the abductors of the larynx were involved, but the expiratory muscles of the chest are affected, characterized by cough occurring in paroxysms, accompanied with more or less vocal sound, the barking or crowing character of the cough sometimes occurring suddenly, sometimes at particular periods of the day, usually affecting patients between eight and fourteen years of age—these were the leading symptoms mentioned. On examination of the larynx in these cases, only structural changes were discovered. The second class of cases were those in which the muscles of the larynx alone had been affected, particularly the hyothyroid muscle. The author of the paper then reported one case of chorea of the abductors of the larynx without any affection of the expiratory muscles, and hence no effort at coughing. In this case there was a peculiar ticking in the head which the patient heard and which he could hear, and which he identified as a clicking to-



gether of the vocal cords. He believed that it was a unique case, at least it was in his experience, and, so far as he had been able to find, in literature; that is, a case in which the spasm was rhythmical, and in which it continued during sleep. Third, and which did not, strictly speaking, belong under the head of chorea laryngis, those cases in which the expiratory muscles alone were affected.

Dr. E. Fletcher Ingals, of Chicago, then read a paper on

#### THE TREATMENT OF LARYNGEAL PHTHISIS.

There are three prominent indications: First, to relieve pain; second, if possible to cure the disease; and, third, failing in either of these, to modify the course of the affection and prolong the patient's life. He believed that these indications could be met successfully in quite a proportion of cases. Pain can generally be relieved by topical applications, even though internal medication is of but little avail. The second indication is met best by the combined topical and internal medication. In the third place, we may succeed in modifying or relieving pain, and enabling the patient to swallow, and so prolong life. Dr. Ingals then gave the history of a few cases which illustrated that the indications mentioned could be satisfactorily fulfilled. He recited the history of two cases which illustrated that laryngeal phthisis can be cured when the pulmonary complications are improving. One favorite local application which he had employed was a combination of carbolic acid, morphia, and tannic acid. He had used eucalyptol with benefit in several cases. In his hands iodoform had given but little or no relief from pain, and had failed to produce any perceptible curative effect. His conclusions were that we may meet the first indication better by topical applications than by any other means, and that we may confidently expect to give relief in a considerable proportion of cases. Second, that a limited proportion of cases may be cured by local and general treatment, the former sometimes being the most important factor. Third, that in many fatal cases life may be prolonged by local applications which relieve the patient from the exhaustion of the pain and irritating cough, and at the same time allow digestion of food.

Dr. Wm. C. Jarvis, of New York, read a paper, entitled

#### THE HEALING OF ULCERS IN LARYNGEAL PHTHISIS.

He premised his remarks with a reference to the incredulity of the medical profession regarding the cure of laryngeal phthisis. This was in part due to fragmentary histories of cases reported, insufficient evidence, and claims for cure based upon peculiar methods of treatment. The history of a case was recited in which the phthical ulcers had been entirely healed. The evidence of physicians and specialist from whence the case came, demonstrated conclusively advanced laryngeal phthisis. The lungs had been examined by experts, and coexisting pulmonary phthisis discovered. The treatment was explained in detail. It consisted locally in the frequent use of fine, unirritating sprays; atomized alkaline fluids were employed for cleansing; local sedation was practised, and iodoform freely used. Constitutional medication was considered of much importance to quiet

cough and favor cicatrization, promote sleep, relieve restlessness, and to nurse and nourish the enfeebled body. Change of climate was also considered essential. By carefully combining these means, a patient threatened with death by starvation from painful deglutition, was restored to strength and comfort. One vocal cord had been almost entirely eaten away, firm cicatricial tissue forming the excavation.

He showed there was an analogy between certain forms of phthical ulcers in the larynx, and simple superficial ulcers in the mouth; that sores in the mouth were sometimes produced by the irritant action of perverted buccal secretions upon slight wounds. A pellicle of shellac varnish, or an eschar, afforded protection and facilitated healing. If the lesion happened upon a part in frequent motion, it was converted into a severe ulcer, producing a train of constitutional symptoms resembling in certain respects those of ulcerative laryngeal phthisis. He believed the incipient wound of phthical ulcers could be caused by a violent cough; constant motion, and acrid discharges from the lungs, completed the analogy. Certain forms of phthical ulcers, easily recognizable, could be cured. Far-advanced phthical ulcerations invariably proved fatal.

Dr. F. H. Bosworth, of New York, then read a paper entitled

#### PARESIS OF THE CONSTRUCTOR MUSCLES OF THE PHARYNX, SIMULATING SPASMODIC STRICTURE OF THE OESOPHAGUS, WITH REPORT OF CASES.

The histories of five cases were given, which illustrated the myopathic affection, what we had been taught to regard a myopathic paralysis, neurotic in character. Dr. Bosworth believed that the affection was essentially muscular, and could be best explained by the general law that muscles which are overworked show a tendency to break down, and this tendency is especially marked if they are situated just beneath a diseased mucous membrane. The author of the paper then spoke of the inherent tendency in certain muscles of the larynx to become the seat of myopathic paresis. His cases were treated with rest, strychnia, salt-water bathing, etc., and all the patients except one recovered.

Dr. Cohen, of Philadelphia, regarded this class of cases as essentially hysterical, certainly the majority of them as they had occurred in his practice. He had obtained the greatest success by placing a nurse over the patient and insisting that food should be swallowed.

Dr. Langmaid, of Boston, had had the best success in their treatment by passing bougies, beginning with a very small one, and advancing gradually to one of large size.

Dr. Knight, of Boston, had had similar cases, but there was no loss of electro-muscular contractility. He had felt that in most cases the difficulty was due to hyperæsthesia, and was best overcome very much in the way mentioned by Dr. Langmaid.

Dr. Bosworth said the question of hysteria was excluded in his cases, because there was unquestionable sluggishness of the muscles, and anæsthesia when touched with the probe.

The Association then adjourned to meet at 11 a. m., on Tuesday, May 22.

The annual dinner of the Association was given at Delmonico's, in the evening at 7 o'clock.

#### SECOND DAY.

Dr. T. R. French, of Brooklyn, read a paper on  
PHOTOGRAPHING THE LARYNX,

which concluded as follows:

The results of the experiments made this year may be summed up as follows:

1. Better photographs have been taken with the stationary apparatus than those of last year.

2. A camera has been so adapted that it can be held in the hand and be quickly placed in position. This makes it possible to photograph the larynx in patients whose fauces are only moderately tolerant.

3. The photographs are taken instantaneously by a drop-shutter, thus making it possible to photograph the larynx even if the parts are in motion.

4. The parts reflected in the mirror are alone exposed, thus avoiding the confusion which arises when the mouth and lips are included and out of focus.

5. As the apparatus is so small, and the exposure is made instantaneously, if desirable, photographs can be taken without the patient being aware of the object of the procedure.

6. Several diseased conditions of the larynx have been photographed. This is an important step in advance, for we believe that it is the first time that it has been accomplished.

7. Portions of the rhinoscopic image have been photographed.

The photographs show, among other things, hypertrophy of the mucous membrane covering the posterior portion of the nasal septum. So far as we are aware, this is the first time that any portion of the posterior nares has been photographed.

Dr. H. A. Johnson, of Chicago, reported five cases of congenital tumor of the larynx.

Dr. Wm. Porter, of St. Louis, communicated a paper on

#### LARYNGEAL PARALYSIS FROM ANEURISM.

Laryngeal paralysis, he said, though a common sequence of thoracic aneurism, is not always the first evidence of the lesion. He presented notes of three cases in which the patients had, when first seen, no other subjective symptoms than those caused by the laryngeal condition.

The first had hoarseness and slight dyspnea for two months, gradually increasing. There were no evidences of chest trouble, but by the laryngoscope could be seen the left cord fixed nearly in the median line. The opinion that there was pressure upon the left recurrent nerve was confirmed by the sphymographic tracing of the left radial artery, which was characteristic of the lesion suspected. The tracing at the right wrist was normal. In a few months, the direct evidences of aneurism were easily found, and the affected cord receded to the "cardiac" position, showing that both adductor and abductor filaments of the recurrent nerve were pressed upon. The patient had since died of rupture of aneurism.

The second case resembled the first in the more important particulars, but, although yet alive, has undoubted evidence of aneurism.

The third case, but recently seen, was one in which the hoarseness and change in voice were due to paralysis of the abductors of the right cord. No intra-laryngeal cause could be found, and as over the region of the ascending aorta near the arteria innominata, a bruit could be heard and slight thrill felt, an aneurism at this point was diagnosed. In this case the sphymograph showed abnormal tracing at each wrist, which aided in fixing the location.

It is not a rule that an aneurism of this part of the aorta should press upon the right recurrent nerve, unless of large size. The proof of aneurism, however, is almost complete, and there is nothing else as yet found to cause the laryngeal paralysis. The patient returned to his home in the South, and Dr. Porter has not been advised of any change in his condition.

In all of these cases the patients sought relief from the laryngeal condition, not knowing of the thoracic lesion, and, in the first two, there was nothing in the chest to indicate it. We know that aneurism may exist without appreciable bruit or impulse, but these symptoms as well as increased area of dullness, are generally present when there is lesion enough to produce pressure upon the laryngeal nerve, and, in this, these two were also exceptional.

In all, as is generally true, the abductor filaments were first affected, but in the first as the pressure became greater, the adductor filaments became also impaired, and the changes in voice and respiration consequent were very interesting.

In these instances the sphymograph gave valuable aid. It may not always give evidence of existing lesion, but where certain deviations from the normal tracings are obtained we can certainly trust its corroborative testimony. The importance of a laryngoscopic examination is self-evident in cases like those reported.

Dr. Louis Elsberg then read a paper on

#### REFLEX PHENOMENA DUE TO NASAL DISEASE.

In the discussion which followed, Dr. Mackenzie emphasized the importance and insisted upon the great frequency of cough as a symptom of nasal disease. Clinical observation and experimental investigation had led him to the following conclusions:

1. That in the nose there exists a well-defined and sensitive area, whose stimulation, either through a local pathological process, or through an irritant introduced from without, is capable of producing an excitation which finds its expression in a reflex act or in a series of reflected phenomena.

2. That this area corresponds, in all probability, with that portion of the nasal membrane which covers the turbinated corpora cavernosa.

3. That reflex acts are produced by stimulation of this area, and are only exceptionally evoked when the irritant is applied to other portions of the nasal mucous membrane.

4. That all parts of this area are not equally susceptible to irritation, the most sensitive spots being, probably, represented by those portions of the membrane which cover the inferior half of the lower turbinated bone, and the erectile body on the septum immediately opposite.

5. That the susceptibility to irritation varies in

different individuals; in some the slightest touch is sufficient to produce the reflex act, whilst in others it can only be produced after long-continued irritation.

That the reflex tract is limited to the above area is rendered probable by the following clinical facts:

1. That where reflex cough exists, this is the area chiefly, if not solely, involved.
2. That the act may be induced by artificial irritation of the diseased structure.
3. That it may be dissipated by topical applications to, or removal of, the diseased membrane.
4. That polypi give rise to reflex phenomena only when they arise from or infringe upon the sensitive area.
5. That in cases where foreign bodies, such as pins, become impacted in the above area, reflex cough will sometimes occur, which latter is not observed when they lodge in the non-sensitive part of the nose.

Dr. Seiler said that he had reported in the *Archives of Laryngology* two cases of reflex irritation due to nasal disease, and gave the history of a case of chorea due to hypertrophies which was cured by the removal of the hypertrophies. He also mentioned the existence of cases, which he believed to be neurotic, in which a sudden copious discharge from the nose, accompanied by sneezing, headache, and so forth, of a watery fluid, attacked the patient, and continued for some time, to disappear as suddenly as it had set in.

Dr. Clinton Wagner then read a paper on

#### SMELL, HYGIENICALLY AND MEDICO-LEGALLY CONSIDERED.

He discussed the physical nature of odors, and pointed out the fact that many of them owed their characters to odorous particles held in suspension, while others were purely gaseous. The smells of various diseases, and different individuals were considered, and the fact that the sense of smell was analogous to that of sight in many respects; it can be cultivated and rendered keen by exercise, can be dulled by fatigue or over-use, and can be suddenly destroyed by overpowering odors. Where the sense of smell is lost by public nuisances, damages may be obtained from the municipality. The existence of odors is one important indication of the existence of certain causes of disease, which should be removed and destroyed.

After which Dr. Harrison Allen, of Philadelphia, presented some remarks on

#### ASYMMETRY OF THE NASAL CHAMBERS WITHOUT SEPTAL DEVIATION.

The subject of asymmetry of the nasal chambers, he said, can be considered from two points of view, viz., from the changes in proportion due to deflection of the nasal septum; and second, from the standpoint of inequality of the chambers themselves in subjects in whom the nasal septum is straight. The group last mentioned will form the basis of the present communication.

As a result of observation of ten examples of crania, selected from the anatomical cabinets of Philadelphia, it may be concluded that a difference in the diameters of the posterior nares can be detected. In the living subject, the writer has reason to believe that the same asymmetry in the posterior nares can be discerned, and that, at

least in the persons of those reporting for the relief of catarrhal affections, the number exhibiting such asymmetry is much larger than would appear from the examination of crania. As the result of clinical study in this direction, extending over the last two years, he concludes that nasal obstruction may be limited to one side of the nasal chambers only; and that such tendency to obstruction may be due to the congenital narrowing of this passage, the nasal septum remaining without deflection.

It is not necessary at this time to attempt an elaborate description of this variety of conformation of the nasal chambers, with its clinical applications, but simply to call attention to a fact which appears to have escaped observation, or, at least, to have received so little attention in the minds of observers as not to enter into questions of diagnosis and prognosis of nasal disorders. It is quite evident that imperfect nasal respiration, due to the above-mentioned cause, cannot be relieved by any operation on the septum, as these operations are at present defined, and that no operation short of drilling away the entire inferior turbinated bone will be likely to afford relief.

It is interesting to remark that among the crania exhibiting the above peculiarities, the best-marked examples were found in the skulls of idiots, in whom marked asymmetry of the cerebral fossæ was also seen. It is not at all unlikely that the real solution of the subject of congenital asymmetry, without septal deflection, is to be found in the peculiarities of development of the cerebral hemispheres themselves; and that the study of this subject can not be separated from the general subject of bilaterality; that is, the general subject of right and left symmetry as controlled by the cerebral nervous system.

(To be continued.)

#### A Final Word on the New York Code Quarrel.

With this title, the *Louisville Med. News* of May 19 gives an editorial thrashing to those recalcitrant New Yorkers who are endeavoring to upset the old code, and thus valiantly defends the Flints.

"The Flints, Austin sr., and jr., seem to be singled out as the chief objects of attack by the malevolent malcontents, who seek to overthrow the code, and to assume the dictatorship of the medical profession of America. Austin Flint, jr., barring Dr. Gross and Dr. Austin Flint, sr., has done more than any living American to make our profession illustrious. A great man himself, and the son and grandson of great men, he needs no eulogy. The world knows and admires him. Austin Flint, sr., is not only America's, but, since Sir Thomas Watson's death, he is the world's most eminent physician. Blameless man and stainless gentleman, of peerless eminence in medicine, he should be elected, as we believe he will be, the next president of the American Medical Association. In making Dr. Flint its chief magistrate, the Association will honor itself more even than it will the recipient of the office, and at the same time will vindicate the honor and honesty of the profession by the election to its highest office of so prominent and faithful and steadfast a defender of its code.

"We are for Austin Flint and the old code. For Dr. Flint forever, and for the code so long as it is the creed of the American Medical Association."

#### British Medical Association.

The fifty-first annual meeting of the British Medical Association is to be held in Liverpool on July 31 next and the three following days. Dr. A. T. H. Waters is the President elect. An address in Surgery will be delivered by Reginald Harrison, F. R. C. S.; and an address in Pathology, by C. Creighton, M. D. The arrangements are as follows: On Tuesday, July 31, church service at the Pro-Cathedral, 10:30 a. m.; first general meeting, 3 p. m.; adjourned general meeting, 8:15 p. m. On Wednesday, August 1, second general meeting and address in Surgery, 11 a. m.; sectional meetings, 1:30 to 5 p. m.; soiree in the Arts Gallery by the President and local committee, 9 p. m. On Thursday, August 2, third general meeting and sectional meetings, 10 a. m.; sectional meetings, 2 to 5 p. m.; public dinner in the Philharmonic Hall, 6:30 p. m. On Friday, August 3d, fourth general meeting, address in Pathology, and sectional meetings, 10 a. m.; concluding general meeting, 2 p. m.; soiree by the Mayor of Liverpool at the Town Hall, 9 p. m. On Saturday, August 4, excursions to various places of interest will be held.

#### German Apothecaries.

Berlin, with a population of 1,122,385 in 1880, had but sixty-nine apothecary shops, or one to every 16,266 of the population. This does not, of course, include the drug stores, which are not kept by licensed apothecaries, while many drugs are also sold in grocery stores. In Germany, the number of apothecaries being limited by law, each receives a better support, and there is less competition than in this country.

In Leipzig there is one to 10,000 inhabitants; in Cologne, one to 7,964; in Hanover, one to 8,207; in Breslau, one to 12,423; in Stuttgart, one to 7,151; and in Königsberg, one to 9,438.

#### Census of Providence, R. I.

A census of Providence, taken in the month of January by men of experience and responsibility, shows a total population of 116,755, of whom 55,736 were males, and 61,019 were females. The gain in population since the United States census of 1880 is 11,898, or 11.34 per cent., an average of 4.53 per cent. annually.

#### One of the Numerous Nuisances of New York.

The health authorities have found that in laying the pipes for supplying the city with steam, gas has been liberated from the saturated ground, and that the composition of tar and other materials with which the pipes have been covered also gives out a sickening smell when heated.

#### A Mammoth Model of the Human Brain.

Dr. Schulgu, of Heidelberg, has constructed a model of the human brain of such dimensions (25 vol.) that every fibre or fasciculus can be traced from the spinal cord to the cortex, or some of the ganglia of brain.

#### Items.

—Mr. Arthur Benson reports a case of retinitis albuminuria, without constitutional disturbance.

—Among the million of paupers aided by the public charities of England in 1865 there were eight hundred thousand drunkards.

—St. Louis is supplied with water gas for fuel purposes, made by the Lowe process. The laying of the pipes is progressing, with ten miles under contract.

The *Chemist and Druggist*, April 14, 1883, says that the taste and smell of turpentine are best masked by sulphuric ether. A mixture of turpentine 3 ij., ether 3 j., syrup of orange 3 j., and water 3 iv., can be taken in teaspoonful doses quite readily.

—The *Cincinnati Lancet* says that "the business of looking after the health of that city is vested in a health board whose active members are two saloon-keepers, two druggists, and one politician."

—The report of the Vaccination Bureau of New York city shows that in the year 1882 the physicians of the Board of Health performed 99,661 vaccinations. In the last seven years nearly 500,000 persons have been vaccinated by members of the bureau.

—The forms of pessaries figured in recent works on gynecology are as varied as the inventive genius of man can make them. Some resemble a grasshopper, some the devil-fish, some the horse-shoe, some the side-saddle, and others are but plain rings.

—A glue ready for use is made by adding to any quantity of glue common whiskey instead of water. Put both together in a bottle, cork it tight, set aside for a few days, and it is ready for use. In cold weather it may have to be placed in hot water for a few minutes before it gets soft.

#### MARRIAGES.

BOYER-WOLFF.—Tuesday, April 24, 1883, by Rev. G. W. Dubois, Walter N. Boyer, M. D., and Miss Laura V. Wolff, at the residence of Mr. and Mrs. Charles H. Wolff, the bride's parents, in Mt. Washington, O.

HIGGINS-OAT.—In Philadelphia, by Rev. S. S. Belville, of the N. J. Conference, M. E., Dr. F. C. Higgins, of Defiance, Ohio, and Miss Emma Belville Oat, of Philadelphia, Pa.

TAGGART-GRANT.—In Shenandoah, Pa., April 30, by Rev. F. F. Kolb, Dr. David Taggart, of Frackville, Pa., and Mary Grant, of Shenandoah.

TINKER-SANGER.—On Tuesday, May 15, at the residence of Horace B. Claffin, Brooklyn, by the Rev. Thomas B. McLeod, Horace H. Tinker, M. D., and Anna P. Sanger.

#### DEATHS.

BRADFORD.—In New York, suddenly, May 10, at his late residence, No. 15 West 48th street, Theodore Dwight Bradford, M. D., in the 45th year of his age.

BUCKNER.—At Shelbyville, Ky., Friday, May 4, 1883, Rev. D. Edmund P. Buckner, aged 61 years.

LATIMER.—In New York, on Tuesday, May 15, Jennie B., wife of Dr. C. E. Latimer, aged 46 years.

PAULDING.—May 1, 1883, in the 30th year of his age, at Fort Sidney, Neb., Captain Holmes Olfley Paulding, Assistant Surgeon U. S. Army, only son of the late Commander Leonard Paulding, U. S. Navy.

PHISTER.—In this city, on the 18th of May, Benjamin Phister, M. D.

STOKES.—In this city, on May 12, of Bright's disease, Dr. Chas. Stokes, son of H. M. and the late Dr. T. J. P. Stokes, in the thirty-eighth year of his age.